B5050-7-U

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RETIREMENT HOUSING INDUSTRY 1987

Health Care
Life care Community
Continuing Care
Retirement Community
Assisted Living
Personal Care Facility
Independent Living Units
Adult Congregate Living Facility
Senior Living Facility
Retirement Community
Real Estate

RETIREMENT HOUSING INDUSTRY 1987

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PREFACE

This year a new dimension has been added to Laventhol & Horwath's study of the retirement housing industry. The pictorial essay dispersed throughout the pages of this publication helps to focus on the issues facing providers and developers of retirement housing and services to the elderly.

The five areas we have chosen as subjects for the pictorial essays are: sponsorship, marketing, programs and services, financing, and design and architecture. These areas were selected because of their particular interest to participants in the industry. By highlighting these topics, we hope to stimulate your imagination to the possibilities and challenges in the retirement housing field.

Through the study's statistical presentations, assessments of various regions, articles and the pictorial essay, the reader should gain greater insight into the current industry environment and its future direction.

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Executive Offices:
1845 Walnut Street, Phila., PA 19103
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Museum of Modern Art, 1954

Sponsorship

It takes many hands to create a successful senior living facility. Designers, architects, developers, operators, gerontologists, lawyers, lenders, consultants, marketers, health care corporations and real estate firms are just some of the many players that may comprise the development team of a typical project.

Each set of hands brings different strengths to the job. The combined talents of the members of the team provide a strong frame work for developing the retirement housing facility. The synergy that is created contributes to the ultimate success for sponsors and residents.

The retirement housing industry, perhaps more than any other, lends itself to the multi disciplinary approach with each party contributing its specialized knowledge of a field. Despite short term frustrations inherent in such a diversity of disciplines, when the entire team works together, a more successful project is the likely result.

INTRODUCTION

by James F. Sherman, Partner;
National Director, Public Finance and
Health Care Consulting,
Laventhol & Horwath

Today, unlike any time in history, the population aged 65 and over can expect many more years of vigorous living. This generation of elderly has taken better care of themselves through exercise and nutrition, and advancements in medicine actually are continuing to improve the quality of life. Armed with their health, financial independence, retirement years, and freedom from the responsibilities of children and work, this pioneering group is exploring the possibilities of life after age 65.

By the year 2000, 20 percent of the population will be over age 65, and the sheer size of this demographic segment makes the elderly a formidable group that will continue to gain market clout and voting power well into the future. As the need for retirement housing grows significantly over the next five years, the industry that serves those needs will continue to evolve and develop new programs and services.

In light of these developments, the second half of the 20th century will be noted for the achievements and vitality of its aging population and will mark a change in the way the elderly live. For many years, Laventhol & Horwath has studied and recorded the changes associated with the graying of America. Through this research, Laventhol & Horwath has surveyed the independent living accommodations now in existence and has reported on the growing demand for diversified services and specialized housing. Opportunities exist for those who can successfully match their products to market needs.

The goal of this annual study is to assist those who develop housing and services to seize the opportunities created by this emerging market and to create an awareness of the forces shaping the industry. Regardless of the type of development, an individual project will reach its goals only by responding to the needs of the people who live there. Determining what works and what doesn't is the essence of market research. As market needs have increased, the industry has learned to become more creative and cost sensitive. The information contained in this study can be used as a guide to successful strategies for designing a new facility, penetrating the market, or updating existing projects and services.

In conclusion, Laventhol & Horwath would like to express its thanks to those who have taken the time and effort to participate in this study. They have been instrumental in providing vital information about this ever-changing industry.

THE RATIONALE OF RETIREMENT HOUSING

by Monsignor Charles Fahey

A crucial part of most successful endeavors is a vision—a sense of what is to be achieved. Although many endeavors begin with a clear vision, circumstances often intervene, time passes, and the vision is forgotten. This is true of individual effort as well as that of a field.

It is essential for those who create housing for the elderly to truly understand the needs and desires of this segment of the population. One of the most crucial aspects to recognize about the elderly is that there is no disease *of* old age, although there are diseases associated *with* age. Older persons may have more episodes of illness, and more elderly will suffer from chronic illness than their younger counterparts. However, illness, whether acute or chronic, is not the centerpiece of the aging experience. Rather, the centerpiece of aging is continued personal development and growth that is full and complete.

Developing services for those who are ill, regardless of age, is necessary. Some such places may focus on the elderly. However, those who are designing residential settings for older persons are well advised to subordinate the health facet of facilities and programs to those that emphasize the fullness of life.

The elderly who are entering retirement housing desire the ability to pursue their lives as before and be free, yet have assistance available if necessary. Although the elderly wish to enter a facility where appropriate medical conditions are available if needed, the medical aspect should not be the primary element in designing and marketing housing for the elderly.

A commitment to provide a physical and social environment that will contribute to the continuing intellectual, psychological and physical growth of residents is essential to retirement housing. Projects that maintain a connection with the surrounding community and take advantage of opportunities offered by nearby universities are particularly successful.

Retirement housing, therefore, should be developed as an extension of one's home. The medical-aging aspects should be incorporated in such a way that they become secondary or not noticeable. For example, small changes are important, such as eliminating the use of throw rugs, positioning shelves in places of easy access and good acoustics. These elements consider the needs of aging, but do so in a subtle way.

This approach, based on a sound understanding of the aging and the aging process, not only fulfills the needs of the elderly, but also makes good marketing sense.

Monsignor Charles Fahey is director of Fordham University's Third Age Center and the Marie Ward Doty professor of aging studies. He is chairman of the advisory council of the Department of Aging for New York City and a member of New York State Public Health Council.

THE IMPORTANCE OF PRECISION IN DETERMINING A MARKET AREA AND TARGET MARKET

by Morton Yalish

Many members of the senior living development community mistakenly believe that the elderly are a limitless market. Most facilities are now being targeted to the upper-end market, relying on this misconception as their foundation. In reality, the upper-end senior living market available to any development is likely to be very thin.

Determining a target market has been compared with starting with what you think is an ocean of fish, then realizing that all you really have is a small portion of one school. The total "limitless" market that appears available to a senior living development becomes narrow when subjected to market area determination, product market match, competition and market characteristics. The use of a broad, generalized approach and/or gross data in defining a market area and target market all too often fails to consider the impact of these factors, which leads to decreased reliability in the calculation of fill period, penetration rate, capture base and other criteria used in determining project feasibility.

These factors are not necessarily discouraging. When properly understood and addressed, they can lead to greater success.

Precise data, field survey information and in-depth analysis are required, however, if a development's market area, target market and component segments are to be defined with a high degree of accuracy and detail. Such precision is necessary to provide a trustworthy base for market feasibility analysis and go/no-go decisions.

A case study based on an actual analysis is presented to illustrate the importance of this concept and exemplify these observations based on experience with market research and feasibility analysis for senior living facilities. (In a complete analysis, other factors of equal significance must be taken into account.)

Concerning senior living facilities, experience reveals:

1. The elderly market is large, but is not homogenous.
2. An elderly market can and must be divided into a variety of segments reflective of a particular housing product and the heterogenous nature of the elderly market.
3. One of the most critical factors in researching the market and establishing market feasibility is the determination of a realistic and meaningful market area.

Such a determination is contingent on a careful and subjective analysis of the life style, physiogeographic, attitudinal, political, social and similar factors that have an impact on the elderly market.

A Case Study

This case study illustrates an actual analysis conducted for a site in a suburb of a large Midwestern city. The proposed project is a 250-plus unit continuing care rental facility that contains 83 one-bedroom and 15 two-bedroom apartments, 60 private and 15 semi-private assisted living (personal care) units, and 10 private and 30 semi-private nursing home units.

The market area was defined as the geographic region from which 80 percent or more of the development's residents will be drawn. The prevailing belief holds that a market area can often be defined realistically in terms of an arbitrary, e.g., five, 10, 20-mile, radius around a site. On the contrary, the case study market area is an irregularly shaped area, roughly resembling in shape the state of Texas. The market area definition was based on the following:

- an analysis of the project concept,
- information gathered from an extensive field review of conditions and characteristics of the site,
- immediate vicinity,
- general neighborhood and the surrounding area,
- physical and psychological barriers in the area,
- competition,
- area demographics and
- client input

The resulting boundaries demonstrate the inadequacy of a radius approach: the market area is no more than a few miles across in one location and much wider in another. Any market area, therefore, must be individually defined.

Although certain common factors have a significant impact on the analysis and quantification of a development's market, the actual impact of each differs from project to project, reflecting changes in product, geography, local conditions and market characteristics. Also, similar factors/issues may be identified specific to a given development. Usually significant factors are:

1. The *type* of development. For the case study, the following example will be employed: rental continuing care oriented to middle- to upper-income elderly who want medical support when needed.
2. The age span of the target market (determined by development's continuing care orientation, e.g., leisure, independent living, nursing care).
3. The necessity for discounting counts of certain market area elderly household types (determined by matching specific household types to the development). In retirement housing, the most significant type is the one-person female household. Husband/wife households and "other" households are not as attracted to retirement communities as are one-person households. Normally, the husband/wife and "other", e.g., a household comprised of an elderly brother and sister, market segment counts are discounted by as much as 50 to 75 percent for continuing care facilities offering medical services.
4. The date of initial occupancy (required to adjust proposed rents and household counts to reflect changes between demographic year and date of occupancy).
5. Proposed rents for initial occupancy, including mandatory service charges (needed to determine preliminary income requirements).
6. Reasonable rent-to-income ratio (for income qualification).
7. Proportion of units to be filled from direct network sources instead of project's target market (usually nursing and/or assisted living units).
8. Vacancy rate upon which operating plan is based (to compute penetration rate).
9. Proportion of units to be filled from elderly households within the market area (can be influenced by such factors as association with a larger religious community).
10. Upper income limit. Higher incomes often allow alternatives which are more attractive than the development.

When these factors are addressed and appropriately quantified for a specific development, the term "assumptions" is used in reference to them. These assumptions form the base for the segmentation of the project's target market.

For this case study, the significant assumptions in addition to the development's concept, were:

1. 1989 rents reduced by 20 percent to 1985 levels (the year of the data used).
2. Rent and meal expenditures limited to 70 percent of after-tax income (roughly equivalent to 60 to 63 percent of gross income). This represents an unusually high proportion of income used for rent and services, reflecting the completeness of the rent-inclusive amenities/service package.
3. Homeowner equities ranging from $50,000 to $90,000, which would yield an average annual annuity of $5,000.
4. Active housing resale market.
5. Nursing units to be filled from network sources, not from market area households.
6. Age ranges adjusted by five years to bring into "sync" the demographics and the facility's opening.
7. Seven percent vacancy rate.
8. Target market households to fill 80 percent of units.

The accompanying series of graphics serve as an illustration of the case study. The series assumes, and is based on, a meaningful and realistically defined market area. It should be emphasized that in this case study the market area definition process provides the first major refinement of the market.

Chart 1, Market Area Households, illustrates the first, and major, "cut"—the breakdown of elderly and non-elderly households in the market area. Elderly households are defined by the Census Bureau as those households where the head of the household is age 65 or over. This market area contains in excess of 150,000 persons, or over 68,000 households. Many developers have assumed that a market area of that size must be able to support a significant amount of retirement housing. But that number grossly exaggerates market size.

First, the number of elderly households must be determined (in this case, 12,335 or only 18 percent of the total households), and then a development's target market and its component market segments must be identified. The target market is specified in both qualitative (market segments suited to the development) and quantitative (market segment counts within the market area) terms. The market segments have been derived by a careful analysis of the development's product service mix to determine which specific elderly households are most suitable for attraction to those product-service types. In this case, the broad elderly household portion of the market area has first been narrowed by stipulating that only those households with households (heads) age 70 and over are to be considered. (At the year of opening, these household heads

Chart 1

MARKET AREA HOUSEHOLDS
68,748 Households

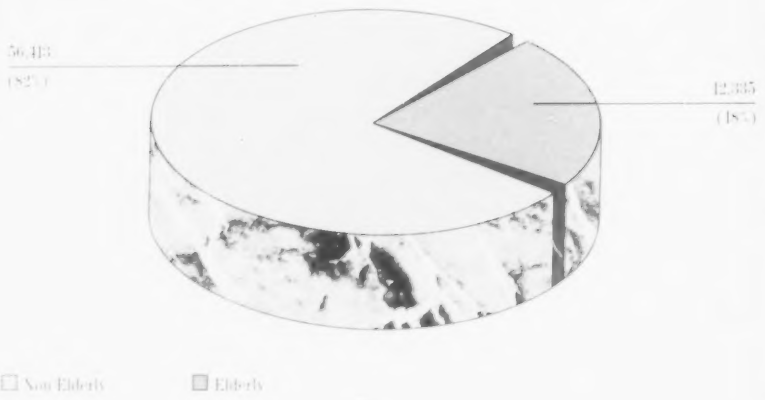
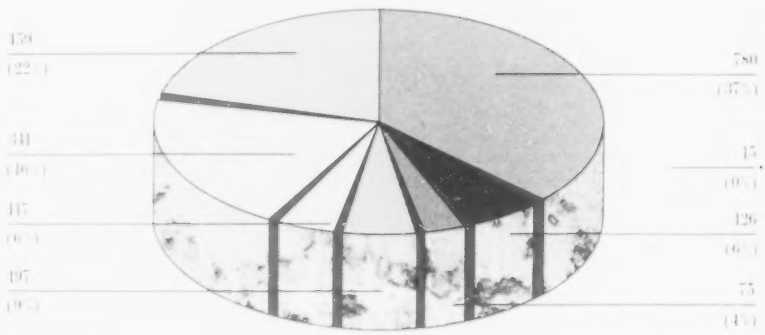


Chart 2

TARGET MARKET
2,110 Households, Householder Age 70+ (In 1985)



Income Ranges:
1 Person Owner: $12,500—50,000**
Husband-Wife and "Other" Owner: $17,500—50,000**
1 Person Renter: $15,000—50,000
Husband-Wife and "Other" Renter: $20,000—50,000

1 Person Female Owner
Husband-Wife Owner*
1 Person Male Owner
Other Owner*
1 Person Female Renter
Husband-Wife Renter*
Other Renter*

*Discounted by 50
**Owner entry levels are lower due to the estimated additional income from annual annuity value of house proceeds
***Male Renter

would be 75 years old. Deaths were calculated separately.)

Eight major segments of the target market of elderly households are portrayed in Chart 2, each a combination of household type and tenure. These eight segments are further stratified by different income levels within each segment, according to the requirements of the product-service mix.*

The effects of a more definitive analysis become more evident in Chart 3. The target market that is most suited to the development is, only approximately one-sixth of all of the elderly households in the market area—2,110 or 3 percent of all households! It is obvious that penetration rates and other feasibility criteria based solely on the gross number of elderly households could contain an inherent high risk factor.

Another issue which must be considered when analyzing a target market is the annual move rate of each market segment, which differs from segment to segment. Chart 4 illustrates the estimated number of households (174) within the target market, classified by three major segments, which can be expected to move in any one year, given current estimated elderly move rates. This signifi-

Chart 3

1985 MARKET AREA ELDERLY HOUSEHOLDS
12,335 Households

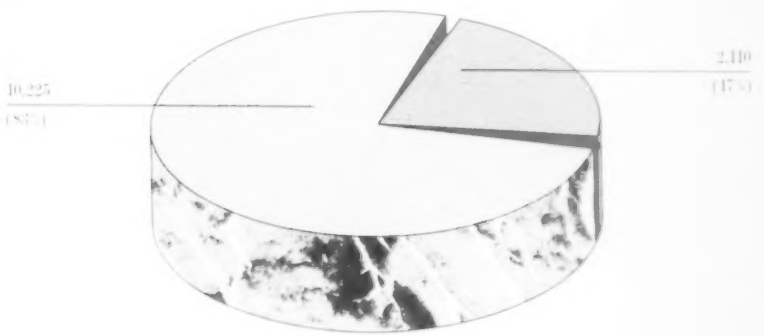
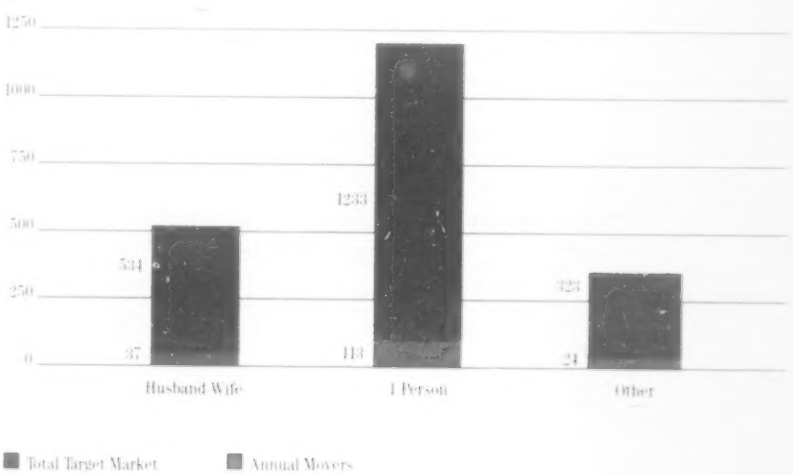


Chart 4

MOVE RATES: BY MARKET SEGMENT



*Weights are obtained for each segment, stratified by income levels, from Laventhol & Horwath's proprietary Elder Care SiteProfile (ESP) data base. ESP is custom run for the market area. In addition to the information already indicated, it provides home value-rent information cross-classified to income. This data allows a determination of the total after tax income available to each market segment, including yield from investment of homeowner equity and money currently being spent on rent by market area elderly renters.

cantly affects the number of households available for "capture" in any one year, and can be extremely critical to a development that is highly dependent on a fast fill period. The vast majority of elderly do not move. Accordingly, it is important to estimate the proportion that are going to move in any given year.

Even though the number of households available from the target market on an annual basis is estimated to be 174, not all are available to the development (Chart 5). Approximately 25-30 percent of these "mover households" will move out of the market area. Of the remainder (127), or capture base, a certain percentage will go to meet the annual turnover requirements of competitive facilities. Some will move to apartments or to non-elderly households e.g., to live with children. In this case, the capture base is unable to accommodate the development's annual requirement of 70, which is the number of market area target households needed to accomplish fill within the allotted period.

Chart 6 graphically summarizes the dramatic thinning of the market, beginning with total market area households and stepping down to the development's annual capture.

As can be seen from this analysis, developing a target market the retirement living development community can be

Chart 5

ANNUAL TARGET MARKET
174 Households

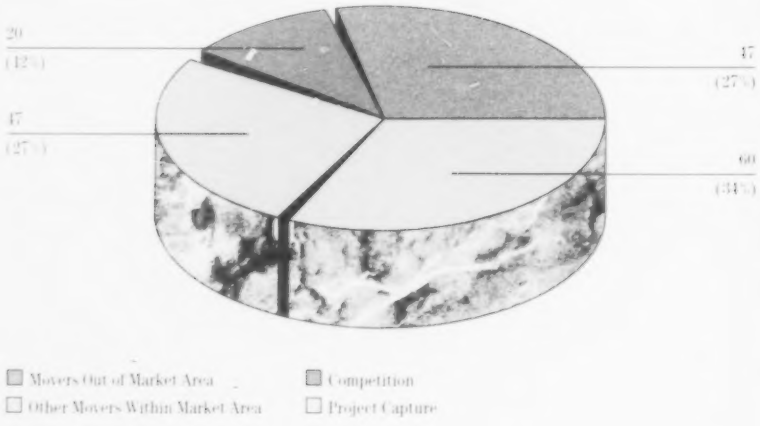
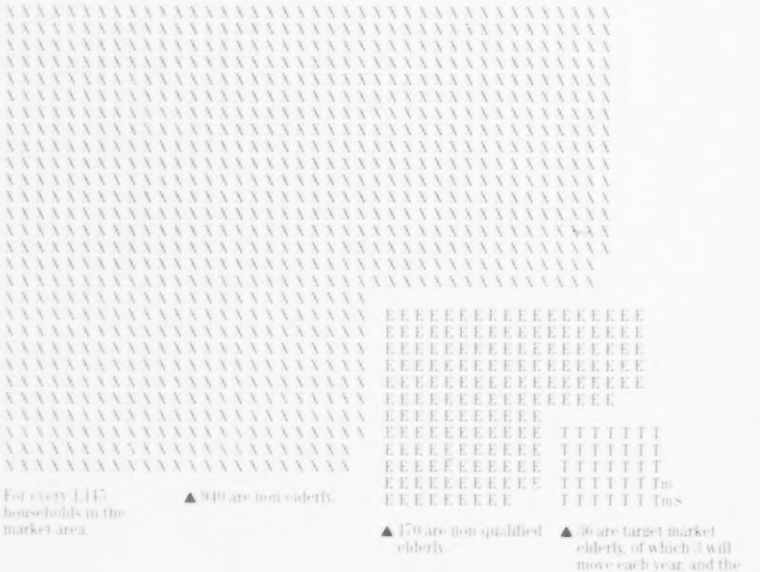


Chart 6

MARKET AREA SUMMARY


For every 1,147 households in the market area,
▲ 940 are non-elderly,
▲ 170 are non-qualified elderly,
▲ 36 are target market elderly, of which 3 will move each year, and the project will capture 1.

compared with fishing for a small select school of fish. Most households in the market area will not qualify for the development's annual capture. Those involved in developing retirement housing, therefore, must clearly understand the true nature of the elderly market—its inherent limitations and unmet opportunities.

Morton Yulish is a senior principal in Laventhol & Horwath's Health Care Advisory Services Group in Philadelphia who specializes in analysis of the retirement housing market and consumer life styles. Previously, he was chairman of Public Demographics, Inc., which merged into L&H.

PERSONAL CARE: THE FURTHER UNBUNDLING OF THE RETIREMENT CENTER CONCEPT

by Thomas A. Luchi and Denis J. Lucey, III, M.D.

The much heralded concept of the graying of America is evidenced through the actual demand for services by the retired population. Not only has competition among providers of these services increased, but also, the level of sophistication of the purchasers and providers of services has grown. Both groups are beginning to realize that the population over age 65 is not homogeneous, and may be as heterogeneous as the entire population. The increased level of sophistication has resulted in segmentation of market demand and market niching as a competitive strategy in providing services to the elderly population.

One particular niche receiving increasing attention is the frail elderly. This segment of the population, because of age and health status, seeks an increase in support services to permit longer residence outside the nursing home, even when independent living becomes impossible. These needs and desires of the frail elderly have given rise to the development and, as some say, the resurgence, of personal care facilities.

Although definitions of personal care facilities and services vary among states and projects, for the purpose of this article, a personal care project is defined as a shelter and service coordination that meets the needs of individuals who are semi-dependent or semi-independent, depending upon one's viewpoint. These individuals typically are single elderly who are incapable of living alone or with the assistance of another elderly impaired individual, yet do not need full-time nursing care.

The personal care facility offers comprehensive services, short of nursing care. All meals are provided and a full-service housekeeping program cares for the individual's unit. The emphasis on assistance with daily living activities constitutes the principal difference between a personal care unit and an adult congregate living facility. While the level of services offered will vary with an individual's needs, the program typically includes administering medications, assistance with bathing, grooming and dressing, and personal transportation, both within and outside the facilities. Also included may be a regimen of therapies geared toward maintaining the individual's ability to live outside a nursing home setting.

There is nothing new about the personal care concept. For many decades a variety of facilities bearing different names have traditionally provided for the frail elderly among the lower-income elderly population. In Minnesota, the facilities have been entitled board and lodging, or board and care homes, depending upon the level of services provided. Michigan has a licensing category for facilities that are called homes for the aging, which are constructed to meet nursing home standards but do not provide nursing care. In Iowa and California, personal care

facilities are called residential care facilities; in Illinois, sheltered care facilities; in Florida, adult congregate living facilities; in Pennsylvania, boarding homes and personal care facilities, and in New York, residential health related facilities. Although no central catalogue of all facility types in the United States exists, some states have established licensing programs for personal care, either as part of the health facility licensing process or the licensing of lodging facilities.

The market for personal care is relatively narrow. It includes individuals aged 75 and older, although most elderly requiring such services are aged 80 and older. Available statistics suggest 30 percent of the population aged 75 and older may require a level of daily living assistance that a personal care unit offers. The market is both demand and need driven. For example, the decision by an elderly person to move into a retirement center is largely discretionary and, therefore, defined as a demand that the individual can satisfy in various ways. However, a decision to move into a nursing home is usually determined by need; the family or the family physician makes the decision, based upon the few alternatives available to meet the individual's physical circumstances. The personal care decision is driven by a combination of demand and need.

Public policy support for an alternative to nursing home care influences the state-of-the-art of personal care in virtually every instance. In response to the needs of the elderly population, personal care facilities are being developed in three different settings: lifecare or continuing care retirement centers, adult congregate living facilities (ACLF) and freestanding facilities.

Lifecare/Continuing Care Retirement Centers

In the traditional lifecare continuing care retirement center, an introduction of personal care signifies the facility's recognition of the importance and economic value of each element of continuing care as residents age, and needs change. These projects have always been faced with the problem of residents "aging in place," given the facility's commitment to the total care of the resident. Whether a facility offers, and residents pay for, "lifecare" or simply a campus environment in which individuals can receive the services necessary at the various stages, the incentive is to provide the most cost effective care available. This can be loosely translated into delaying admission or transfer to the nursing home facility as long as possible as well as minimizing acute care and chronic institutionalization.

By identifying a discrete level of care, a facility can enable residents to better understand what can be expected from the program as well as the available options should the need for an increased level of service arise.

In the lifecare continuing care setting the principle decision concerning personal care focuses on where this care will be offered. Is it a special segment of the nursing home unit that provides a less intense level of care? Is it a separate residential unit that minimizes the cost of providing shelter through smaller, less completely equipped units, e.g., no kitchens as the trade-off for a more labor-intensive delivery of services? Or is it a program of services provided to residents in their units, similar to home care? This decision should be based upon specific market demand, the program's image, e.g., nursing facility model versus home care model, and the economics of providing the services.

Adult Congregate Living Facilities*

As with the lifecare continuing care retirement center developments, the adult congregate living facility (ACLF) must address the problem of "aging in place." Many facilities avoid the problem by restricting residency to persons capable of living independently. Another approach is the addition of an element of the continuing care concept to the service package. The major issue focuses on the decision to provide personal

* In the strictest sense, an adult congregate living facility refers to a service-enhanced retirement housing facility. In Florida, however, the term is a legal definition that refers exclusively to licensed personal care facilities.

care services to residents no longer capable of living independently, who may be forced to leave the facility, but do not yet require nursing home care. Some economic motivation exists to maintain the individual as a resident as long as possible, even to the point of residents only leaving the ACLF to be admitted to full-service nursing homes.

The ACLF would approach personal care in a similar manner to a lifecare facility that decided to provide services to individuals in their residential units. Through the establishment of a program or a preferred vendor contract with an outside agency, a comprehensive home care program would be made available to residents and include intensifying the level of 24-hour supervision as well as the other services outlined above.

Key decisions involve whether to offer an a la carte menu of services, providing residents with options based upon their needs, or to package services at various levels to standardize delivery. Whether the facility managers provide services or contract with an outside agency will depend upon two factors: the desired level of control and the economies of scale in relationship to the size of their project. Some ACLFs have negotiated favorable "volume" contracts with home health agencies based upon the concentrated demand the ACLF can deliver.

Some ambivalence exists regarding the provision of personal care within the ACLF environment; it is desirable to minimize facility turnover by maintaining residents in their units as long as possible, yet, this "aging-in-place" will increase the average age of the population. This could make remarketing of the facility to a younger population more difficult, since potential residents may be reluctant to associate with individuals confined to wheelchairs, walkers or their own units.

Freestanding Personal Care Units

This method of providing personal care targets the market niche between independent living facilities (ACLFs) and the traditional nursing home. Current activity is vigorous, and although freestanding personal care units have the appearance of a new concept, they most closely represent a rethinking of the longstanding concepts outlined at the beginning of this article. The exception is in their economic focus—upscale for the middle- and upper-income frail elderly.

A number of factors, varying among markets, creates opportunity in this segment. Intense public pressure to minimize nursing home services because of increased use of limited public (state) dollars to pay for these services exists in some areas. Changing family structure, especially the growth in dual wage earner households, has not only created the economic resources to purchase such services, but also, the necessity for them because of the reduced number of care givers willing to support the elderly in an independent setting or take them into their homes. In addition, the demand seems to be increasingly generated by the upper-income market as defined by both the elderly's individual and the family resources.

An individual's length of stay in a freestanding personal care unit is relatively short. While this may change as the public becomes more accustomed to this concept, the decision to move into a personal care facility now seems to be delayed until the last possible minute, i.e., need predominates in the decision. Hence, personal care facilities often receive individuals in transition to a nursing home.

The personal care concept, however, can be applied to a wide range of individuals relative to their independence. In Minnesota, two variations on the personal care theme are being developed. Carefree Living, an upscale version of the board and lodging or board and care concept, targets a market physically capable of living independently but desiring three meals a day, full housekeeping and the psychological security of a nurse on duty 24 hours a day. The units

are designed as hotel rooms with a combined sleeping and sitting area and bath, with no kitchen facilities. The program's design attempts to keep individuals in common areas for much of the day.

The Elder Homestead is targeted at dependent individuals. A small number of private sleeping units share a common living facility. The individual has his own sleeping and sitting quarters and a minimal kitchen facility that provides a psychological reinforcement of independence. The package includes a minimum number of nursing hours per week and other support facilities clearly targeted for individuals requiring assistance with daily living.

The interest in, and resurgence of, personal care reflect current trends toward deinstitutionalization of long-term care for the elderly. While personal care targets a specific market niche, several competitors exist, the most obvious being home care. In the last five years advances in home care have permitted individuals to remain in their homes for a longer period of time. In addition, some states are screening admissions to nursing homes and diverting nursing home reimbursement dollars to alternative programs that maintain individuals in their homes. Therefore, the concept of providing personal care in an adult congregate living facility may become a more feasible and desirable alternative, but also is obviously more competitive with home care.

Some nursing homes have empty beds, the result of pressures to reduce utilization of their services. This represents potential competition with freestanding personal care units as nursing home operators begin to seek alternative uses for these beds, in which they have already made a capital investment, and with the support facilities necessary to provide personal care with a nursing care-oriented model.

The availability of community support services also poses competition for the personal care facility. Many communities have taken an active role in providing for the needs of their elderly population with programs such as Meals On Wheels, check-in services, lifeline services, shared housing and companion programs. The success of a personal care facility may depend upon the lack of, or unacceptability of, these community services.

As with any sound product, personal care must be market and economic driven. Personal care facilities will not be universally accepted and successful in every market. Each individual market must be evaluated to determine if the targeted niche is sufficiently large and underserved, thus allowing for the project's success. This applies particularly to the incorporation of a personal care facility into ACLF or the development of a freestanding facility.

Particularly in regard to the lifecare and the ACLF development, a project must make sense economically. The creation of another level of care within a lifecare center may create more problems and expense if one is only building in another move within a campus development. An operator of an ACLF needs to balance the desirability of maintaining the residents in their units as long as possible with the impact on marketing the facility.

While clearly potential need exists nationally, a sound local rationale for a personal care development should be established before a decision for implementation is made.

Thomas A. Luchi is the practice leader for the Health Care Management Advisory Services in Laventhol & Horwath's Minneapolis office.

Denis J. Lucey, III, M.D. is a senior principal in Laventhol & Horwath's Philadelphia Health Care Practice, with a particular interest in seniors' housing and chronic care.

REAL ESTATE DEVELOPMENTS—CONDOMINIUMS AND COOPERATIVES

by Frank C. Romano, Jr.

The basic concept of continuing care retirement communities is not new—it has been evolving in Europe and the United States for many years, culminating approximately two decades ago in Quaker lifecare communities. When moving into a continuing care retirement community, as in any group living situation, people seek convenience, security and opportunities for social contact with peers. Any continuing care retirement community, therefore, must include the following at a reasonable cost:

- comfortable living quarters,
- services and amenities package, and
- a program providing for residents' future health care needs that does not create fear of extravagant costs.

Numerous models for communities offering these qualities have arisen over the years. The first, and perhaps the best known, is the lifecare or endowment community. Residents make a substantial payment or endowment prior to entering the community and receive services on a contractual basis. The contract guarantees that the community will provide residents all necessary long-term care at no additional cost. In addition to the endowment, residents often pay a monthly fee to defray daily living expenses.

The lifecare or endowment community competes with the second model, the traditional rental concept. Under terms of the lease agreement, the resident pays a monthly rent that includes the cost of all services and is offered a long-term care insurance program, which pays a significant portion of future long-term care costs. The care would be provided in the community or in an affiliated long-term care facility located nearby.

A third model that has only recently been considered a viable alternative is the ownership concept—either on a condominium or cooperative basis. Residents own residential units and are provided with a service package paid for by monthly fees. As with the rental approach, the ownership model includes a long-term care insurance program. Without belaboring the legal nuances, a condominium can be defined as a community in which residents hold legal title to their apartments and share with other residents the ownership of common areas, e.g., hallways and lounges. The owners have a joint obligation to support operating costs and maintenance of these common spaces. An association of owners has decision-making powers for the community. A cooperative, however, is owned by a single corporation and residents own shares. The bylaws of the corporation establish the rights and obligations of occupants.

A dramatic change seems to have occurred recently in developers' views of continuing care retirement communities. The ownership concept is becoming the model of choice, and condominium or cooperative arrangements are being proposed at locations nationwide.

Ownership has gained popularity for many reasons. The first, and most obvious, is the change in the Federal tax law, effective January 1987. The new law has substantially lessened the value of tax shelters in real estate that are conducted as limited partnerships. Many people are predicting higher rents as a result of the loss of tax benefits for investors. Although some new limitations were imposed, a homeowner can still benefit from the interest deduction on his home and one other residence.

For the elderly, the new tax law has even greater significance. An elderly homeowner who is planning on selling his existing home and renting a new home will find he has less funds with which to work. For example, an elderly homeowner wants to sell his primary residence valued at $300,000. Upon the sale of this property, the homeowner would be eligible for a $125,000 one-time deduction. But if the home was debt-free, owned for 30 years and its basis was (for this example) $30,000, the amount of gain on the sale to be taxed would be $145,000. Under the old tax law, 60 percent of the gain would have been exempt from tax, and the amount of tax would be reduced by income averaging.

In a worst case scenario, the seller of the home would have paid a tax of 20 percent on the gain; many taxpayers would have paid less. Under the new tax law, the homeowner would be faced with a 28 percent tax rate and possibly a rate as high as 33 percent on a portion of the gain. The owner would end up with a significantly higher tax bill under the new law.

Conversely, if the homeowner could have purchased a new home, perhaps in a retirement community, then the balance would have been reinvested and there would be little, if any, tax liabilities. Even upon the death of the individual, the uniform estate and gift tax credit would, in most cases, allow the additional equity to be passed on to heirs tax free. Thus, investing proceeds from the sale of a house into an ownership arrangement in a retirement community is a desirable alternative to rental.

A second reason ownership models interest developers involves the increased regulation of lifecare facilities by state governments. Governmental concern has resulted from questions about the financial viability of some lifecare communities that base their ability to support the enormous costs of long-term health care on a relatively small pool of residents. Some states are now requiring elaborate disclosure and economic feasibility studies on proposed lifecare or endowment communities before allowing development.

Financing presents the third reason for the increased interest in condominiums and cooperatives. Lenders are more responsive to the quicker generation of cash, resulting from the sale of condominiums as opposed to a long-term, hence unpredictable, income from rental projects. For the developer it is more efficient to obtain financing for ownership communities.

But perhaps the most compelling reason for developers to consider the ownership model involves the residents of a community. One of the most frequent dilemmas faced by people in the retirement industry is breaking the age barrier. Can people below 75 years of age be attracted to what is typically known as a retirement community? If age reduction could be achieved, the demand for these communities would more than quadruple in the foreseeable future. Ownership, a sense of financial independence and a decision-making role for residents of a condominium or cooperative would provide a dramatic break from the somewhat institutional atmosphere and the "we'll take care of everything" philosophy that has turned many people away from retirement communities. David Wolfe of Wolfe Resources, along with many industry visionaries, has noted that the ownership option fits into his theory of the importance of life satisfaction for the elderly. Ownership indicates financial independence and a sense of self-worth and satisfaction.

Growth and opportunity describe the future of the continuing care retirement community. I am convinced that the industry will witness the increased use of condominiums and cooperatives, producing dramatic consequences for developers and residents. Residents will be presented with a greater variety of residential and service packages, and a broader choice will be available for those considering full-service living. These ownership options will attract a greater diversity of residents and a more vigorous and younger population. This broader mix of inhabitants will instill both vitality and purpose to these communities and provide an opportunity and a challenge to the development industry.

Frank C. Romano, Jr. is president of Elder Care Services Incorporated, a company that develops and operates retirement communities, and vice president of the National Association for Senior Living Industries.

HOSPITAL INVOLVEMENT: RESPONDING TO AN AGING AMERICA

by Richard Giancello

America is aging and the health care industry must respond. Older Americans will soon become health care's primary consumers, representing not just a market segment that the hospital industry must target, but the market of the future. A population continuing to age, the burgeoning growth in the retirement housing industry and hospitals' decreasing market share are making the elderly a viable, if not necessary, target market for diversifying hospital services.

The History of Involvement

The Social Security Act of 1935 is considered the beginning of the era of social programs for the elderly. Most program recipients at this time were paupers, orphans, the disabled and the mentally ill. Even as recently as 20 years ago, industry experts still viewed retirement housing as warehousing for the elderly. The offering by most facilities of only small private or semi-private accommodations with three meals per day and virtually no other amenity or service package fueled this misconception.

Today's elderly population, however, is more affluent, healthy, independent and diverse than the elderly population 20 years ago. Therefore, the retirement housing industry has had to change and diversify to meet the needs of the elderly population.

Church-affiliated organizations, offering what is commonly referred to as the "lifecare" community, entered the retirement housing industry first. Residents paid an up-front, usually non-refundable fee plus a monthly rental fee. In return, residents were guaranteed lifetime health care and a generous service/amenity package.

Hospitals had limited involvement in lifecare for several reasons. First, the financial risks were very high, because of the difficulty in predicting the resident's future health care expenditures. Second, mission statements of hospitals 20 years ago were less broadly defined, and related strictly to providing health care services. Third, diversifying services to remain competitive was not critical to a hospital's survival.

Today, however, many of these issues have changed. The elderly population is the most frequent user of hospital care. According to the Center for Health Statistics, the elderly population accounts for more than 30 percent of all hospital discharges and over 41 percent of all patient hospital days. Due to the current Medicare reimbursement system, it is to the hospital's advantage to discharge an elderly patient as soon as possible. Having a network of housing and long-term care facilities gives a hospital the ability to respond to incentives set forth by Federal and state reimbursement programs by providing care to the elderly in the least costly setting while maximizing income.

The mission statements of most hospitals have changed dramatically over the past few decades. Currently, many mission statements encompass a broader spectrum of social issues and incorporate meeting the social and health care needs of the community it serves. In addition, diversification is the key to a hospital's success. Hospitals that carefully consider all the available housing options and move ahead with those that meet their specific goals and community needs will have a greater chance at succeeding. These factors explain the recent hospital involvement in the retirement housing industry.

Entering this industry generally requires a multi-million dollar real estate investment that is specifically designed to meet the needs of a targeted elderly market. The hospital board of trustees, before making a final decision to enter the retirement housing market, should carefully consider the following factors:

1. Conformity With Mission Statement

A hospital must first ascertain that entering into a real estate venture is within the scope of its mission statement. Because retirement housing differs dramatically from other hospital services, a project must be scrutinized. If entering this marketplace conforms with the hospital's mission statement, then the trustees must clearly

understand the purpose for offering this service. Whether increasing market share, enhancing the hospital's community service image, or providing a greater referral base, the purpose must be agreed upon by all voting members of the board, who must also understand the risks and rewards associated with the type of retirement center under consideration before proceeding with the project.

2. Legal Structure of the Retirement Housing Entity

The development, ownership and operation of a retirement housing entity can be legally structured in several ways. The final decision will depend upon the hospital's corporate structure as well as its mission statement. Two of the most popular legal structures are a separate corporation and a partnership.

Structuring a separate corporation is advantageous for hospitals that wish to develop more than one project. Several hospitals have created a separate tax-exempt or taxable corporation. Establishing a new corporation allows the hospital to separate the assets of the retirement project from those of the hospital for reimbursement purposes, as well as for the preservation of the hospital's debt capacity.

The retirement project's purpose generally dictates whether the newly formed corporation should be for-profit and taxable or not-for-profit and tax-exempt. Taxable corporations offer freedom from operating restrictions imposed by a tax-exempt status, including compliance with rules concerning private inurement and unrelated business income. Additionally, income from a taxable retirement housing project could be passed through to the parent company shareholder in the form of dividends, and then transferred to the hospital in the form of charitable contributions.

Conversely, tax-exempt corporations offer the advantage of sheltering income through a Federal income tax exemption as well as allowing the project to qualify for tax-exempt financing vehicles. Any excess revenues generated by the project could be transferred to the hospital as charitable contributions.

If a hospital has an available parcel of land and is considering the development of just one facility, then a land-lease and/or partnership structure would be most advantageous. By joint venturing with an experienced developer and/or operator, the hospital can increase its ability to raise required capital as well as to limit the developer risk.

3. Financing Vehicle

Four financing vehicles most often used by hospitals entering the retirement housing industry are tax-exempt bond financing, taxable bond financing, commercial financing and the Federal Department of Housing and Urban Development (H.U.D.)-sponsored financing.

Tax-Exempt Financing

Relatively low interest rates and equity requirements often make tax-exempt financing the first choice for hospitals. Hospitals, as 501(c)(3) corporations, still qualify under the new tax laws for tax-exempt financing as long as the hospital owns and/or operates the facility. A hospital must carefully evaluate the use of tax-exempt bonds because of the effect on the hospital's rating and debt capacity. The hospital's overall rating may be lowered if the retirement center financing comprises a major portion of the hospital's overall debt.

Taxable Financing

If the legal structure of the corporation owning/operating the facility is not a qualified 501(c)(3) corporation, then taxable financing may be obtained. Generally, this financing vehicle carries a higher interest rate and a shorter term than tax-exempt financing vehicle. Additionally, taxable financing often requires some percentage of the facility's units to be offered to low-income residents.

Commercial Financing

Commercial financing, although available, is not as accessible as

bond financing. Commercial lenders tend to view retirement housing projects as risky real estate ventures, thus causing a reluctance to lend on these projects. Commercial loans generally carry less financing costs but higher interest rates than bond financing vehicles. Large equity requirements or letters of credit are required for commercial financing.

H.U.D. Financing

The Federal Department of Housing and Urban Development offers a wide variety of senior housing alternatives. The 221-D4 and 232-Board and Care programs are the most utilized. This type of financing offers a long term (up to 40 years) with an attractive interest rate. Equity requirements range from 5 to 15 percent, depending upon program, type of project and initial working capital requirements.

Rewards and Risks

As hospitals attempt to extend their services to the elderly market, retirement housing projects can provide several rewards and risks, including the following.

Rewards:

- the exemplification of the hospital's mission to serve its elderly constituents from a social and health care perspective
- a new pool of potential hospital referrals to maintain and strengthen the market share
- a new source of revenues to help support hospital services
- diversification into new markets

Risks:

- the long-term investment of development, which means returns will often not be realized until after the fourth or fifth year of operation
- entering a new market in which facilities being developed must be operated very differently from a hospital to realize a profit
- management's need to focus on meeting the needs of the elderly and understanding that they are providing a new life style to their residents
- large investments that could have a negative impact on debt capacity and bond ratings and could limit the amount of funds available for future hospital expenditures

In the future many hospitals will be forced to explore the retirement housing industry in order to maintain their market shares and to remain competitive with other hospitals within their market areas. Several structures will be utilized, but joint venture relationships with private developers will be commonplace, as this arrangement avoids the unfamiliar risks of real estate development and the potential negative impact on a hospital's debt capacity resulting from retirement center investments.

Richard Gianello is partner-in-charge of L&H's San Francisco Health Care and Retirement Consulting Practice. He is also L&H's director of Health Care Consulting for the Northwest region of the United States.

Stump Speaking

George Caleb Bingham (1811-1879)

From the art collection of

The Boatmen's National Bank of St. Louis

Marketing

Being heard in 20th century America takes much more than ascending a stump and speaking one's mind. In a culture where the focus has been on youth, the aging population is oftentimes not truly heard and understood.

Meeting the desires of the current generation of elderly, who possess more resources and options than ever before, and attracting the "young elderly" to retirement housing, require paying careful attention to the elderly's needs. However, even for the concerned developer of retirement housing, obtaining an accurate assessment of this population can be a confusing task. When developed with little or no market research, projects may be misguided, and the overall success undermined.

A market research team can assess the needs of the elderly at a grass roots level. By employing techniques such as surveys and focus groups, valuable information can be obtained from this segment of the population. Then, operational and marketing decisions can be based on this foundation of knowledge.

REGULATION IN THE RETIREMENT HOUSING INDUSTRY

by Joseph W. Piccillo & Henrietta K. Bertelsman

The recent and projected growth in the number of affluent elderly has led to the rapid expansion of the senior housing industry. This industry has evolved from being primarily the domain of nonprofit organizations to include the private sector, which is increasingly attempting to capitalize on profit potential.

State regulatory agencies, particularly those charged with safeguarding consumer rights, have been noticing the growth of the elderly housing industry. An increasing number of states have enacted or are considering enacting legislation to regulate senior housing developments. Typically, lifecare or continuing care retirement communities face the most regulations.

Under the traditional concept of lifecare, residents receive all basic housekeeping services and complete medical care—including nursing home care, in exchange for a one-time, up-front payment and monthly fees. This arrangement is becoming less common, however, as many of the newer developments offer only rental agreements with no large up-front fees or guaranteed health care. Despite variations in the type of shelter and availability of health care, many developments advertise themselves as lifecare communities.

Hence, state regulatory agencies have imposed definitions of what constitutes lifecare or continuing care retirement communities and implemented rules for such living arrangements. Great diversity exists in the scope and specificity of the regulations among states. Some states are primarily concerned with insuring that prospective residents have adequate, accurate information to make decisions about joining and remaining in a community. Other states have established precise regulations for governing the development and operation of such facilities.

Existing state regulations governing senior housing developments can be summarized in five major categories:

1. Preopening requirements—The community may be required to have state certification and to disclose certain financial information to residents. Some states also impose a minimum presale requirement prior to granting a permit.
2. Contracts between the residents and community—Regulations may address the form and content of the resident contract, promotional materials, resident rights, resident councils, liens and terms of withdrawal from the community.
3. Health care requirements—The community may be required to obtain a Certificate of Need (CON) to provide home health care, assisted living or nursing home care and to meet life safety codes for medical facilities. Other CON requirements may include a required admission of a certain number of nonresident Medicaid patients, a restriction on external marketing of the nursing home or other state requirements for construction of a nursing home facility.
4. Financial requirements—Regulations may require escrow deposits before and after occupancy, reserve requirements, performance bonding, annual audits and govern fee adjustments and refunds.
5. Remedial procedures—The steps—taken if fraud, deception or serious financial problems exist or the community refuses to disclose required information—may be stipulated in the regulations.

The retirement community must also comply with regulations not specific to the industry, including zoning and building codes. The community, depending upon its source of permanent financing, may also be subject to further requirements, the most common being of a financial nature.

Table 1 summarizes the approaches that states have taken in regulating areas of critical importance to the development and operation of successful continuing care communities. Although most regulations specify what is expected of the community, a few are vague in their intent, therefore making enforcement difficult.

This summary is only intended to provide an overview of the existing regulations affecting continuing care facilities; it is not intended to be all-inclusive or definitive. The underlying statutes and legal counsel should be consulted as to the applicability of the specific regulations.

In structuring a senior housing project, it is critical that the developer identify what, if any, regulations apply in his locale, early in the development process. Regulatory awareness plays a critical role, as illustrated in the following examples:

- Presale requirements may expand development time and increase project cost.
- Regulations may require state approval of rate increases or prohibit such increases, threatening project viability.
- The presence of CON regulations may have a severe impact on the time and/or potential for development of the health care component of the project.
- Escrow reserve requirements may severely affect cash flow for the project and increase project borrowing.

In the future, regulation is expected to have an even greater impact on senior housing developments.

Although no federal regulation of the senior housing industry exists, the situation is likely to change if growing numbers of retirees choose this life style, or if fraud or management incompetence result in widely publicized instances of failed projects.

An increasing number of states are considering the enactment of retirement housing legislation. Although some of the legislation will be similar to regulations enacted in other states, i.e., primarily targeted at lifecare or continuing care developments, legislation is also likely to be established for areas currently unregulated in many states, e.g., personal care or assisted living facilities, and retirement housing with congregate support services. CON regulations will continue to be an area of scrutiny, controversy and change.

The impact of regulation on the future of retirement housing is uncertain. All-inclusive, exacting regulation may deter growth by developers and sponsors. The absence of regulation may discourage potential residents who are skeptical about a project's financial stability and future. A balance that protects industry growth and consumers will hopefully be reached.

Joseph W. Parrillo is partner-in-charge of L&H's Health Care Advisory Services for the North Central region. Henrietta K. Bertelsman is a manager in Health Care Advisory Services. They are based in the firm's Chicago office.

Arizona
A facility in which a provider undertakes to provide a resident with nursing services, medical services or health-related services, in addition to board and lodging, for life or for a term in excess of one year pursuant to a lifecare contract. Such a contract includes the payment of an entrance fee, together with or in lieu of payment of regular periodic charges for care and services provided.

California
A facility in which a provider, whether a person, association or organization, undertakes to provide a resident with nursing services, medical services, health-related services, board, lodging and care as necessary, or any combination of such services, for life or for a term in excess of one year, pursuant to a lifecare contract. The lifecare contract may require the payment of an entrance fee to the provider, the payment of regular periodic charges for care and services provided, or both.

Colorado
A facility in which a provider, whether a corporation, association, partnership or individual, undertakes pursuant to lifecare contracts, to provide health care, medical services, board, lodging and other necessities to residents for the duration of their lives. The lifecare contract requires a payment of an entrance fee, together with or in lieu of payment of regular periodic charges for care and services provided.

Connecticut
A facility in which a provider, whether a person or business association, undertakes to furnish to a person not related by blood or marriage, shelter and medical or nursing services or other health-related benefits for the life of a person or for a period in excess of one year. A present or future transfer of assets or an entrance fee in addition to or instead of periodic charges is required.

Florida
A facility in which a provider, whether a person, corporation, trust or partnership, or other unincorporated association, undertakes to provide a resident with food, shelter and either nursing

care or personal services for any duration of time pursuant to a continuing or lifecare contact. Such a contract requires the payment of an entrance fee with or without additional periodic charges for services provided.

Illinois
A facility in which a provider, undertakes to provide a resident with nursing services, medical services or personal care services, in addition to board, lodging and other maintenance services, for life or for a term in excess of one year pursuant to a lifecare contract. The payment of an entrance fee, together with or in lieu of payment of regular periodic charges for care and services provided is required.

Indiana
A facility in which a provider, whether an individual, corporation, partnership, association or other legal entity, undertakes to provide five or more residents with any combination of board, lodging, nursing care, medical care or other health-related services, for life or for a term in excess of one month pursuant to a continuing care contract and requires payment of an entrance fee, together with periodic charges for care and services provided.

Kansas
A facility in which a provider, whether a person, corporation, partnership, association or other legal entity, agrees to furnish to an individual for the payment of an entrance fee or periodic charges, or both, living accommodations or meals and related services, or both, in a home possibly but not necessarily, together with nursing care services, medical services or other health-related services, or any combination of such services, for the life of the individual or for a period in excess of one year.

Maine
A facility in which contracts for support of life and is approved by the Probate Court in the county in which the support for life is to be rendered.

Maryland
A facility in which a provider, whether a natural person, partnership, unincorporated association, however organized, trust or corporation, undertakes to furnish a subscriber shelter, medical and nursing services or other health-related benefits for life or for a term in excess of one year pursuant to a continuing care contract. Such a contract requires the payment of an entrance fee and periodic charges for care and services provided.

Michigan
A facility in which a provider, whether an individual, corporation, partnership, trust or other unincorporated organization, undertakes to provide a resident with shelter, food, clothing, medical attention, entertainment or other personal advantage or attention for life or for a term in excess of one year pursuant to any written or oral lifecare contract.

Minnesota
A facility in which a provider, whether a person, partnership, corporation, undertakes to provide a resident with board, lodging, nursing services, medical services or other health-related services, for life or for a term in excess of one year, pursuant to a continuing or lifecare contract. Such contracts require the payment of an entrance fee in excess of $100 and the payment of regular periodic charges for the care provided.

Missouri
A facility in which a provider, whether a person, corporation, partnership or other unincorporated association, undertakes to provide residents with room, board, nursing services and other personal services for life or for a term in excess of one year pursuant to a lifecare contract. The contract requirements include the payment of an entrance fee or the payment of any other recommendation of any type.

New Jersey
A facility in which provides lodging and nursing, medical or other health-related services at the same or another location to an individual pursuant to an agreement effective for the life of the individual or for a period greater than one year, including mutually terminable contracts, and in consideration of the payment of an entrance fee with or without other periodic charges. Entrance fee means a transfer to a provider of a sum of money or other property made or promised to be made as full or partial consideration for acceptance of a specified person as a resident in a facility and includes a fee which is refundable upon the death, departure or option of the resident.

Oregon
A facility which requires the payment of an entrance fee or buy-in charge minus any actual costs incurred by the facility, in the event the resident withdraws from the facility within the first six months of occupancy, and undertakes to provide three or more persons (not related to the provider, at least 65 years old and with less than ownership interest in the facility) with shelter, food, medical care or other services.

Pennsylvania
A facility in which a provider, furnishes to individuals board and lodging, together with nursing services, medical services or other health-related services, for life or for a term in excess of one year pursuant to a continuing or lifecare contract. Such a contract requires the payment of an entrance fee with or without additional periodic charges for services provided.

Texas
A facility in which a person furnishes a member shelter, food, clothing, medical attention, nursing services, medical services, entertainment or other personal advantage or attention for life or for a term in excess of one year pursuant to a life interest or long-term leasing. Payment of an entrance fee is required.

Virginia
A facility in which a provider, whether a person, corporation, partnership or other entity, undertakes to provide a resident with board, lodging and nursing services for life or for a period in excess of one year pursuant to a continuing care contract. Payment of an entrance fee together with or in lieu of payment of regular periodic charges for care and services provided is required. A fee which is less than the sum of the regular periodic charges for one year of residency shall not be considered to be an entrance fee.

Wisconsin
A facility in which a provider, undertakes to provide residents with nursing services, medical services or personal care services in addition to board, lodging and other maintenance services, for life or for a term in excess of one year pursuant to a continuing care contract. A continuing care contract is defined as involving an entrance fee in excess of $10,000, the transfer of at least $10,000 worth of assets or the deferred transfer (upon the resident's death) of at least 50% of a resident's estate.

TABLE 1†

STATE**	ARIZONA	CALIFORNIA
RESPONSIBLE AGENCY	Department of Insurance	Department of Social Services
INVESTIGATIVE ENFORCEMENT POWERS	No	Yes
PREOPENING REQUIREMENTS		
Certificate of Authority Permit	Yes	Yes
Certified Financials	Yes	Yes
Copy of Resident Contract	Yes	No
Disclosure Statement	Yes	No
Copy of Escrow Agreement	Yes	No
Feasibility Study	Yes	No
Actuarial Study	Yes	No
Pre-Sale Requirement	No	Yes
CONTRACT REGULATIONS:		
Submission to State	Yes	Yes
Form & Content	Yes	Yes
Refund Provisions	Yes	Yes
Residents' Rights	Not Available	Yes
FINANCIAL REQUIREMENTS		
Fees Escrowed Until Occupancy	Yes	Yes
Release of Funds Regulated	Yes	Yes
Reserve Requirements	Yes	Yes
Surety-Fidelity Bond Requirements	No	Yes
Disclosure to Residents	Yes	Yes
Annual Financials	+ previous 2 years	No
Actuarial Studies	Every 5 years	No
Annual Filings	No	Yes
HEALTH CARE REQUIREMENTS		
Certificate of Need	No	No
REMEDIAL PROCEDURES		
Advertising Regulations	No	Yes
Lien Provisions	Yes	Yes

STATE	COLORADO	CONNECTICUT
RESPONSIBLE AGENCY	Department of Insurance	Department on Aging
INVESTIGATIVE ENFORCEMENT POWERS	Yes	Yes
PREOPENING REQUIREMENTS		
Certificate of Authority Permit	Yes	Yes
Certified Financials	Yes	Yes
Copy of Resident Contract	Yes	Yes
Disclosure Statement	Yes	Yes
Copy of Escrow Agreement	Yes	Yes
Feasibility Study	No	Equivalent
Actuarial Study	No	Yes
Pre-Sale Requirement	No	Yes
Other		5 Year Projections
CONTRACT REGULATIONS:		
Submission to State	Yes	Yes
Form & Content	Yes	Yes
Refund Provisions	Yes	Yes
Residents' Rights	No	Yes
FINANCIAL REQUIREMENTS		
Fees Escrowed Until Occupancy	Yes	Yes
Release of Funds Regulated	Yes	Yes
Reserve Requirements	Yes	Yes
Surety-Fidelity Bond Requirements	No	No
Disclosure to Residents	Yes	Yes
Annual Financials	Yes	Yes
Actuarial Studies	No	Annual Projections
Annual Filings	Yes	Yes
HEALTH CARE REQUIREMENTS		
Certificate of Need	No	Yes
REMEDIAL PROCEDURES		
Advertising Regulations	Yes	No
Lien Provisions	Yes	No

† As of July 1, 1987

** New York — Regulations: Prohibition of prepayment for more than three months. Title 10 New York Code of Rules and Regulations, Section 415.1(f)(1). Operator shall not enter into any contract or agreement with a patient, resident, next of kin, and/or sponsor for lifecare of patient or resident." Title 10 New York Code of Rules and Regulations, Section 414.10(B). Monitored by Department of Health, New York State.

STATE	FLORIDA	ILLINOIS
RESPONSIBLE AGENCY	Department of Insurance	Department of Public Health
INVESTIGATIVE ENFORCEMENT POWERS	Yes	Yes
PREOPENING REQUIREMENTS		
Certificate of Authority Permit	Yes	Yes
Certified Financials	Yes	Yes
Copy of Resident Contract	Yes	Yes
Disclosure Statement	Yes	Yes
Copy of Escrow Agreement	Yes	Yes
Feasibility Study	Yes	Yes
Actuarial Study	Yes	Yes
Pre-Sale Requirement	Yes	Yes
CONTRACT REGULATIONS		
Submission to State	Yes	Yes
Form A Content	Yes	Yes
Refund Provisions	Yes	Yes
Residents' Rights	Yes	Yes
FINANCIAL REQUIREMENTS		
Type Escrowed Until Occupancy	Yes	Yes
Release of Funds Regulated	Yes	Yes
Reserve Requirements	Yes	Yes
Surety, Fidelity Bond Requirements	Yes	Yes
Disclosure to Residents	Yes	Yes
Annual Financials	Yes	Yes
Actuarial Studies	Yes	Yes
Annual Filings	Yes	Yes
HEALTH CARE REQUIREMENTS		
Certificate of Need	Yes	Yes
REMEDIAL PROCEDURES		
Advertising Regulations	Yes	Yes
Fees Provisions	Yes	Yes

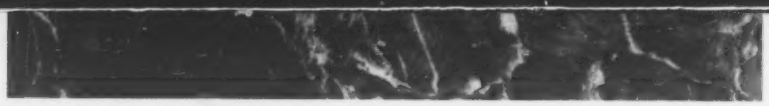
STATE	INDIANA	KANSAS
RESPONSIBLE AGENCY	Department of Securities	Department of Insurance
INVESTIGATIVE ENFORCEMENT POWERS	Yes	Yes
PREOPENING REQUIREMENTS		
Certificate of Authority Permit	Yes	Yes
Certified Financials	Yes	Yes
Copy of Resident Contract	Yes	Yes
Disclosure Statement	Yes	Yes
Copy of Escrow Agreement	Yes	Yes
Feasibility Study	Yes	Yes
Actuarial Study	Yes	Yes
Pre-Sale Requirement	Yes	Yes
CONTRACT REGULATIONS		
Submission to State	Yes	Yes
Form A Content	Yes	Yes
Refund Provisions	Not Available	Yes
Residents' Rights	Not Available	Yes
FINANCIAL REQUIREMENTS		
Fees Escrowed Until Occupancy	Yes	Yes
Release of Funds Regulated	Yes	Yes
Reserve Requirements	Yes	Yes
Surety, Fidelity Bond Requirements	Not Available	Yes
Disclosure to Residents	Yes	Yes
Annual Financials	Yes	Yes
Actuarial Studies	Yes	Yes
Annual Filings	Yes	Yes
HEALTH CARE REQUIREMENTS		
Certificate of Need	Yes	Yes
REMEDIAL PROCEDURES		
Advertising Regulations	Yes	Yes
Fees Provisions	Yes	Yes

*CON still exists for long term care facilities until 1988. Private pay long term care beds exempt effective July 1, 1985.

STATE	MAINE	MARYLAND
RESPONSIBLE AGENCY	Probate Court	Office of Aging
INVESTIGATIVE / ENFORCEMENT POWERS	No	Yes
PREOPENING REQUIREMENTS		
Certificate of Authority / Permit	No	Yes
Certified Financials	No	No
Copy of Resident Contract	No	No
Disclosure Statement	No	Yes
Copy of Escrow Agreement	No	Yes
Feasibility Study	No	Yes
Actuarial Study	No	No
Pre-Sale Requirement	No	Yes
CONTRACT REGULATIONS		
Submission to State	No	Yes
Form & Content	No	Yes
Refund Provisions	No	Yes
Residents' Rights	No	Yes
FINANCIAL REQUIREMENTS		
Fees Escrowed Until Occupancy	No	Yes
Release of Funds Regulated	No	Yes
Reserve Requirements	No	No
Surety / Fidelity Bond Requirements	No	No
Disclosure to Residents	No	Yes
Annual Financials	No	No
Actuarial Studies	No	No
Annual Filings	No	Yes
HEALTH CARE REQUIREMENTS		
Certificate of Need	Yes	Yes
REMEDIAL PROCEDURES		
Advertising Regulations	No	Yes
Lien Provisions	No	No

STATE	MICHIGAN	MINNESOTA
RESPONSIBLE AGENCY	Department of Commerce — Corporate & Securities Bureau	None
INVESTIGATIVE / ENFORCEMENT POWERS	Yes	No
PREOPENING REQUIREMENTS		
Certificate of Authority / Permit	Yes	No
Certified Financials	Yes	Yes
Copy of Resident Contract	No	No
Disclosure Statement	Yes	Yes
Copy of Escrow Agreement	No	No
Feasibility Study	Yes	No
Actuarial Study	No	No
Pre-Sale Requirement	No	No
CONTRACT REGULATIONS		
Submission to State	No	Yes
Form & Content	No	No
Refund Provisions	Yes	Yes
Residents' Rights	Yes	No
FINANCIAL REQUIREMENTS		
Fees Escrowed Until Occupancy	Yes	Yes
Release of Funds Regulated	Yes	Yes
Reserve Requirements	No	Yes
Surety / Fidelity Bond Requirements	Possible	No
Disclosure to Residents	Yes	Yes
Annual Financials	No	No
Actuarial Studies	No	No
Annual Filings	Yes	Yes
HEALTH CARE REQUIREMENTS		
Certificate of Need	Yes	No
REMEDIAL PROCEDURES		
Advertising Regulations	Yes	No
Lien Provisions	No	Yes

*Moratorium currently in effect for the construction of additional nursing home beds



STATE	MISSOURI	NEW JERSEY
RESPONSIBLE AGENCY	Division of Insurance	The Division of Housing & Development, Department of Community Affairs
INVESTIGATIVE ENFORCEMENT POWERS	Yes	Yes
PREOPENING REQUIREMENTS		
Certificate of Authority, Permit	Yes	Yes
Certified Financials	Yes	No
Copy of Resident Contract	No	No
Disclosure Statement	No	Yes
Copy of Escrow Agreement	No	No
Feasibility Study	No	No
Actuarial Study	No	No
Pre-Sale Requirement	No	No
CONTRACT REGULATIONS		
Submission to State	Yes	No
Form & Content	No	No
Refund Provisions	Not Available	No
Residents' Rights	Yes	Yes
FINANCIAL REQUIREMENTS		
Fees Escrowed Until Occupancy	Yes	Yes
Release of Funds Regulated	Yes	Yes
Reserve Requirements	Yes	Yes
Surety, Fidelity Bond Requirements	No	Yes
Disclosure to Residents	Yes	Yes
Annual Financials	No	No
Actuarial Studies	No	No
Annual Filings	Yes	No
HEALTH CARE REQUIREMENTS		
Certificate of Need	Yes*	Yes
REMEDIAL PROCEDURES		
Advertising Regulations	Yes	No
Lien Provisions	No	Yes

STATE	OREGON	PENNSYLVANIA
RESPONSIBLE AGENCY	None	Department of Insurance
INVESTIGATIVE ENFORCEMENT POWERS	Not Available	Yes
PREOPENING REQUIREMENTS		
Certificate of Authority, Permit	No	Yes
Certified Financials	Yes	Yes
Copy of Resident Contract	No	No
Disclosure Statement	No	Yes
Copy of Escrow Agreement	No	No
Feasibility Study	No	No
Actuarial Study	No	No
Pre-Sale Requirement	Disclosure of Potential Liabilities	Requires 4 Certificates of Authority
CONTRACT REGULATIONS		
Submission to State	No	Yes
Form & Content	No	Yes
Refund Provisions	No	Yes
Residents' Rights	No	Yes
FINANCIAL REQUIREMENTS		
Fees Escrowed Until Occupancy	No	Yes
Release of Funds Regulated	No	Yes
Reserve Requirements	No	Yes
Surety, Fidelity Bond Requirements	No	No
Disclosure to Residents	No	Yes
Annual Financials	No	No
Actuarial Studies	No	No
Annual Filings	No	Yes
HEALTH CARE REQUIREMENTS		
Certificate of Need	Yes	Yes
REMEDIAL PROCEDURES		
Advertising Regulations	No	No
Lien Provisions	No	Yes

*Moratorium currently in effect for new construction

STATE	TEXAS	VIRGINIA
RESPONSIBLE AGENCY	Board of Insurance	State Corporation Commission
INVESTIGATIVE ENFORCEMENT POWERS	Yes	Yes
PREOPENING REQUIREMENTS		
Certificate of Authority Permit	No	Yes
Certified Financials	No	Yes
Copy of Resident Contract	Yes	Yes
Disclosure Statement	Yes	Yes
Copy of Escrow Agreement	No	No
Feasibility Study	Yes	No
Actuarial Study	No	No
Pre-Sale Requirement	No	No
CONTRACT REGULATIONS		
Submission to State	No	Yes
Form & Content	No	Yes
Refund Provisions	No	No
Residents' Rights	No	Yes
FINANCIAL REQUIREMENTS		
Fees Escrowed Until Occupancy	No	No
Release of Funds Regulated	No	No
Reserve Requirements	No	No
Surety Fidelity Bond Requirements	No	Yes
Disclosure to Residents	No	Yes
Annual Financials	No	No
Actuarial Studies	No	No
Annual Filings	No	No
HEALTH CARE REQUIREMENTS		
Certificate of Need	No	Yes
REMEDIAL PROCEDURES		
Advertising Regulations	No	No
Lien Provisions	No	No

STATE	WISCONSIN
RESPONSIBLE AGENCY	Department of Insurance
INVESTIGATIVE ENFORCEMENT POWERS	Yes
PREOPENING REQUIREMENTS	
Certificate of Authority Permit	Yes
Certified Financials	Yes
Copy of Resident Contract	Yes
Disclosure Statement	Yes
Copy of Escrow Agreement	No
Feasibility Study	No
Actuarial Study	No
Pre-Sale Requirement	No
CONTRACT REGULATIONS	
Submission to State	Yes
Form & Content	Yes
Refund Provisions	No
Residents' Rights	No
FINANCIAL REQUIREMENTS	
Fees Escrowed Until Occupancy	No
Release of Funds Regulated	No
Reserve Requirements	No
Surety Fidelity Bond Requirements	No
Disclosure to Residents	Yes
Annual Financials	Yes
Actuarial Studies	No
Annual Filings	Yes
HEALTH CARE REQUIREMENTS	
Certificate of Need	No*
REMEDIAL PROCEDURES	
Advertising Regulations	No
Lien Provisions	No

*Moratorium currently in effect for new construction

THE RETIREMENT HOUSING INDUSTRY 1987

by Melvin S. Katz and Susan Brecht

For the seventh consecutive year, Laventhol & Horwath has conducted a survey of the retirement housing industry. The following pages contain charts and exhibits that provide operational and financial information about currently operating facilities. The statistical tabulations and corresponding narrative have been selected to provide a diversity of information for both experienced operators and new entrants in the industry.

The analysis of the data provided by the *Retirement Housing Industry 1987* has been divided into four chapters:

- Chapter I: Profile of Participants
- Chapter II: General Information
- Chapter III: Entrance Fee Facilities
  - Section A: Physical Plant Characteristics
  - Section B: Resident Characteristics
  - Section C: Revenues
  - Section D: Expenses
- Chapter IV: Rental Facilities
  - Section A: Physical Plant Characteristics
  - Section B: Resident Characteristics
  - Section C: Revenues
  - Section D: Expenses

The sample size of this year's survey is the largest since Laventhol & Horwath introduced the study seven years ago. Responses from 173 facilities comprise the sample, which represents a cross section of the industry in geographic location, size and type of facility.

Our approach to the study has been to report information from respondent facilties and to identify and examine factors that are currently affecting the industry, as well as those that may have an impact on the industry in the future. In certain cases, comparisons are made to the previous year's survey data. Although the universe of respondents was not identical, these comparisons offer useful insights into emerging trends within the retirement housing industry.

Analysis of the data reveals the increasing diversity of retirement housing options for elderly Americans. Entrance fee facilities offer a wide range of refund programs and health care may or may not be included as part of the entrance fee. Many rental communities have on-site nursing homes. "A la carte" options for meals, housekeeping and other services are becoming increasingly popular.

Other findings indicate:

Consistent with the results of previous studies, the average age of residents entering facilities is nearly 80. Despite attempts to market facilities to "adults over 55," the market appeal is to an older segment of the population.

Waiting lists exist at 87 percent of respondent facilities. Approximately one-half of the respondents indicate plans to expand their facilities within the next three years.

Nearly one-half of the rental facilities have a nursing center on the premises, and nearly one-quarter of rental facilities offer personal care/assisted living units.

As with any research study, the value of the survey results should be measured not only by the findings contained in this report, but also, by comparison to previous studies and personal experience. In this way, trends and shifts within the industry can be identified and monitored. Simply stated, the retirement housing industry is evolving.Those participants with the greatest knowledge will be the most successful. Readers of this study therefore, are encouraged to share their views of the survey and their experiences in the industry, which will assist us with increasing the value of future editions.

The *Retirement Housing Industry 1987* study would not be possible without the efforts of survey participants. We would like to acknowledge the valuable contributions they have made to this study.

Melvin S. Katz, senior principal in Laventhol & Horwath, is the firm's national coordinator of long-term care services. He is based in L&H's New York office. Susan Brecht is a manager in L&H's Philadelphia office Health Care Advisory Services Group. She specializes in the retirement housing industry. They are coeditors of the study.

CHAPTER I: PROFILE OF PARTICIPANTS

Profile of Participants

Laventhol & Horwath's seventh annual survey of the retirement housing industry presents data gathered from retirement facilities throughout the United States. From more than 230 respondents, only those meeting the study definition of a retirement housing facility have been included in the analysis. For the purposes of this study, a retirement housing facility is defined as an existing and operating, non-federally-subsidized facility that provides independent living units and, at a minimum, provides meals, housekeeping and/or transportation to individuals age 62 and older. With few exceptions, health care services, ranging from wellness promotion to long-term nursing care are also offered, either through an endowment payment or other financing mechanisms. This broad definition was used because of the diverse options that are available within the industry.

The use of this definition eliminated responses from federally-subsidized complexes, facilities in the pre-operations stage and facilities containing only personal care/assisted living units. The resulting study incorporates data from 173 facilities, the largest number of respondents since the survey began. The respondents are representative of the types of facilities that have been developed throughout the United States.

EXHIBIT I-1: Regional Distribution of Participants

This year's respondents were distributed relatively evenly across the United States. For the most part, the distribution parallels a recent estimate of the regional distribution of the elderly population, which has been included for a comparison.

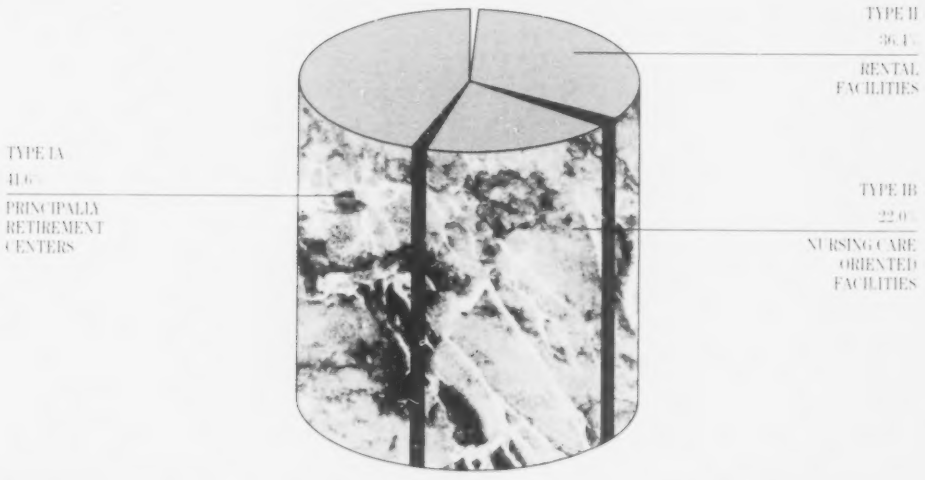
Composition of the Regions:

NORTHEAST—CT, DE, ME, MA, NH, NJ, NY, PA, RI, VT
SOUTHEAST—AL, DC, FL, GA, KY, MD, NC, SC, TN, VA, WV
NORTH CENTRAL—IA, IL, IN, MI, MN, NE, ND, OH, SD, WI
SOUTH CENTRAL—AR, LA, OK, TX, KS, MO, MS
WEST—AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY

Region	Number of Respondents	Percent of Respondents	Percent of Population Over Age 65 (1)
U.S.	173	100.0%	100.0%
NORTHEAST	29	16.8%	23.3%
SOUTHEAST	38	22.0%	22.9%
NORTH CENTRAL	40	23.1%	22.0%
SOUTH CENTRAL	26	15.0%	14.2%
WEST	40	23.1%	17.6%

(1) U.S. Bureau of Census—1985 estimate

EXHIBIT I-2: Distribution of Facility by Type



Respondents have been classified according to the payment options available to their residents. Throughout this report the following distinctions are made:

TYPE I: Entrance Fee Facilities

IA. Principally Retirement Centers
A ratio of more than two independent living apartments per nursing bed is the primary characteristic of these entrance fee facilities. This category contains many facilities known as continuing care retirement communities that typically contain a large number of apartments and a smaller nursing center.

IB. Nursing Care Oriented Facilities
These entrance fee facilities have fewer than two independent living apartments per nursing bed.

TYPE II: Rental Facilities

An increasingly popular option, these facilities charge only a monthly fee. While some rental facilities reported an "entrance fee," this figure was typically equal or double the monthly fee and was considered to be a security deposit for the purpose of this study.

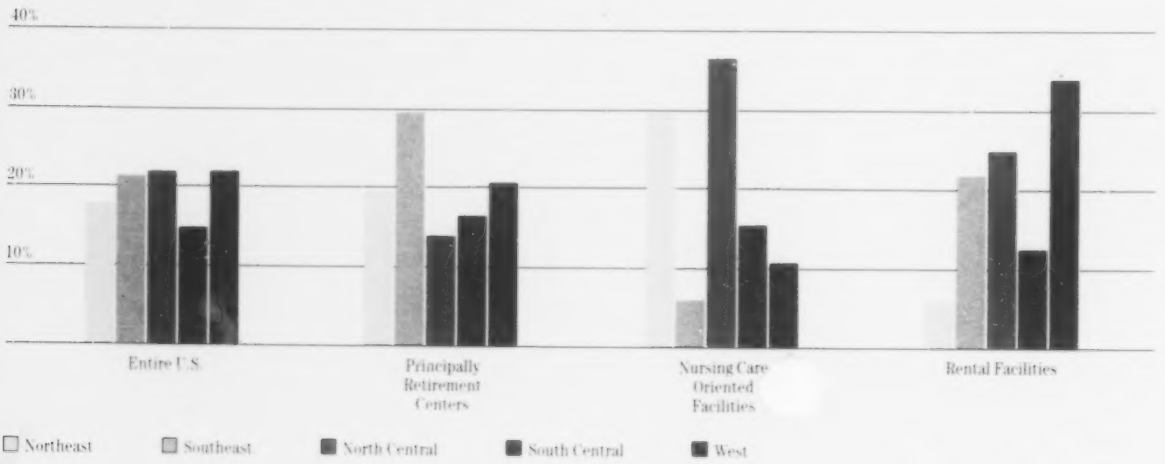
EXHIBIT I-3: Comparison of Total Apartment Units and Nursing Beds

As the table indicates, Type IB nursing care oriented facilities have significantly fewer than two apartment units per nursing bed. A closer inspection reveals that, primarily, these facilities were constructed as nursing homes and later additions were built containing apartments.

Interestingly, Type II rental facilities have fewer apartments/beds than Type IA principally retirement center facilities. In our sample, several large nursing homes have added a small number of rental apartment units, lowering the apartments/beds ratio for these facilities. As rental payments become increasingly prevalent, future studies may divide rental facilities into Types A and B, based upon the ratio of apartments/beds.

	Principally Retirement Centers	Nursing Care Oriented Facilities	Rental Facilities
APARTMENT UNITS	19,335	4,423	8,269
NURSING BEDS	3,782	4,687	2,542
RATIO: APARTMENTS NURSING HOME BEDS	5.1	.9	3.3

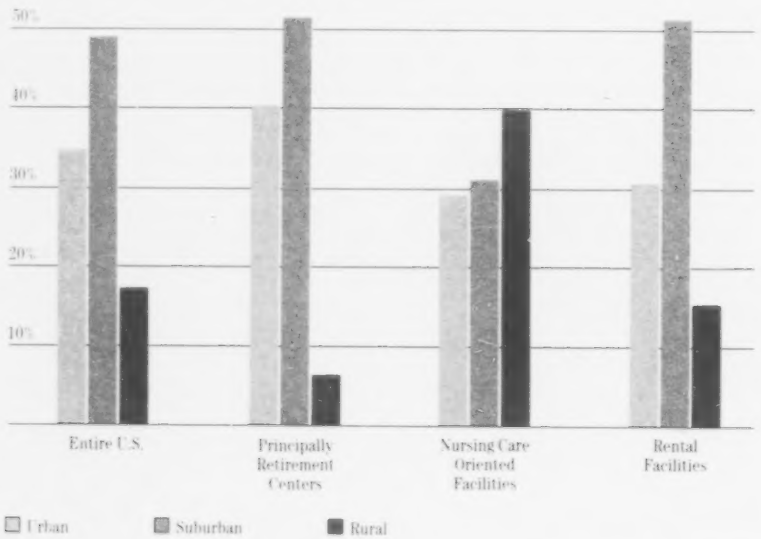
EXHIBIT I-4: Regional Distribution of Participants by Type of Facility



While respondents were distributed relatively evenly across the United States, significant differences are noted in the regional distributions of facility types. Nursing care oriented facilities predominate in the Northeast and North Central regions; the Western region contains a greater concentration of strictly rental respondents.

EXHIBIT I-5: Facility Location by Type of Facility

As in previous years, the smallest percentage of respondents are located in a rural area, particularly Type IA, principally retirement center facilities. Since these facilities tend to be the largest, their size may not be supported by the sparsely populated rural markets.



U.S. Median Size: Apartment Units
Principally Retirement Centers: 108.5 Units
Nursing Care Oriented Facilities: 239.5 Units
Rental Facilities: 82.5 Units

EXHIBIT I-6: Number of Respondents by Selected Criteria

	Entire U.S.	Principally Retirement Centers	Nursing Care Oriented Facilities	Rental Facilities
ENTIRE U.S.	173	72	38	63
OWNED BY A NONPROFIT ORGANIZATION	149	68	37	45
LOCATION:				
Urban	60	29	11	20
Suburban	83	38	12	33
Rural	30	5	15	10
SIZE:				
Under 150 Units	92	15	30	47
150 Units & Over	81	57	8	16
ENTRANCE FEES:				
50% to 100% Refundable Under All Conditions	29	18	11	N.A.
Refundable for Period Fewer Than 50 Months	33	26	7	N.A.
Refundable for Period Longer Than 50 Months	45	33	12	N.A.
No Refund After Period Longer Than 50 Months	19	12	7	N.A.
No Refund Except for Trial Period	23	16	7	N.A.
NURSING CARE INCLUDED IN MONTHLY FEE:				
VIRTUALLY UNLIMITED COVERAGE:				
Built Before 1975	33	17	12	4
Built 1975 & Later	32	27	2	3
LIMITED OR NO COVERAGE:				
Built Before 1975	44	10	16	18
Built 1975 & Later	38	13	7	10
RETAIN A MANAGEMENT COMPANY	40	23	3	14
RETAIN A FOODSERVICE COMPANY	36	18	10	8
REGION OF COUNTRY:				
Northeast	29	14	11	4
Southeast	38	21	3	14
North Central	40	10	14	16
South Central	26	12	6	8
West	40	15	4	21
AGE OF APARTMENTS:				
Built Before 1975	87	29	29	29
Built 1975 & Later	86	43	9	34
NURSING CENTER ON PREMISES	127	57	38	32
PERSONAL CARE/ASSISTED LIVING UNITS	63	29	16	18

*EXHIBIT I-7: Independent Living Unit Mix by Type and Age of Facility**

A trend toward larger retirement housing facilities is noted in Exhibit I-7, as the median of total units for facilities built after 1975 is larger than for facilities built prior to 1975, regardless of facility type. Type IA principally retirement centers are consistently the largest facilities.

Consumer demand for specific unit types can also be inferred from this exhibit. Prior to 1975, most facilities had significantly more studio and one-bedroom units, compared with the total number of units. For facilities built in 1975 or later, an increase in two- and three-bedroom units is observed. Current trends indicate consumer preference for larger apartment units as shown in Exhibit II-8.

	Built Before 1975			Built 1975 & Later		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
ENTIRE U.S.:						
Studio	23 units	65 units	112 units	11 units	28 units	58 units
One-Bedroom	19	45	77	56	95	127
Two-Bedroom	9	30	64	25	52	95
Three-Bedroom	2	3	11	7	16	40
Total Units	60	111	181	88	173	262
PRINCIPALLY RETIREMENT CENTERS:						
Studio	50	71	121	18	30	59
One-Bedroom	41	71	128	85	107	148
Two-Bedroom	8	55	89	39	72	104
Three-Bedroom	2	3	13	8	18	36
Total Units	115	198	322	176	256	320
NURSING CARE ORIENTED FACILITIES:						
Studio	5	17	52	10	16	39
One-Bedroom	14	31	63	17	33	73
Two-Bedroom	12	15	40	14	30	37
Three-Bedroom	1	4	6	**	**	**
Total Units	33	69	128	56	106	166
RENTAL FACILITIES:						
Studio	40	80	117	8	32	88
One-Bedroom	12	25	64	29	102	119
Two-Bedroom	5	22	43	11	26	60
Three-Bedroom	**	**	**	3	28	77
Total Units	56	86	135	72	122	192

*Each item was individually tabulated and does not necessarily add to the totals shown
**Insufficient response

La Représentation

René Magritte (1898-1967)

© 1988 Charly Herscovici - Belgium

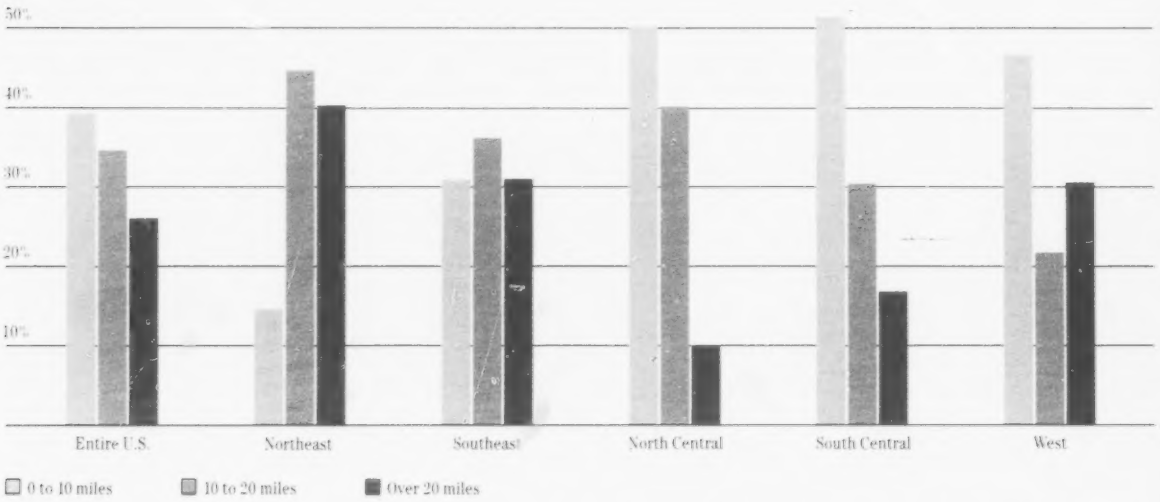
Programs and Services

Depending on an individual's point of view, many of the elderly living in retirement communities are either almost independent or nearly dependent. The way in which the elderly envision their own lives is indeed the most important view of all. For this reason, those who develop retirement housing must respond to the elderly's desire to balance independence with a sense of security in their well being.

A retirement community's best response lies in offering programs and services that allow residents to create their own balance, to continue to express their individuality through the choices they make about their daily lives. To most elderly, moving to a retirement community means having certain conveniences that make it possible for them to live independently for as long as possible. It means activities and the camaraderie of friends their own age. To many, it also means having medical care or a helpful staff nearby for the times when they need some assistance.

A community's programs and services should offer a supportive environment while recognizing residents' need to feel independent. Creating services with this objective requires imagination and a sense of respect for residents and is a crucial element of a project's success.

EXHIBIT II-1: Resident Origin by Region



MEDIAN PERCENTAGE OF RESIDENTS ORIGINATING IN THE SAME STATE AS THE FACILITY

U.S.	82.7%
Northeast	79.0
Southeast	77.6
North Central	90.1
South Central	86.2
West	90.1

Retirement housing residents tend to originate from towns and communities near the facility in which they live. Regional variations in resident origin are revealed in this exhibit. For example, residents of Northeast facilities appear to have exhibited greater mobility in their selection of retirement housing; residents of North and South Central facilities exhibited much less mobility. While the reasons for these movements may be complex, the migration patterns of any market area require careful consideration in order to understand the potential market for a retirement housing venture.

*EXHIBIT II-2: Resident Origin by Facility Type**

Respondent facilities were asked to report the distance of origin for the majority of their residents. Eighty-one percent of Type IA principally retirement centers reported the majority of their residents originated from within 25 miles of the community. Type IB nursing care oriented facilities and Type II rental facilities reported a slightly higher percentage, 87 percent and 88 percent respectively.

When comparing these results with last year's, the most significant change is that residents appear to be moving slightly greater distances to live in retirement housing facilities. In 1986, 43 percent of Type IA, 45 percent of Type IB and 47 percent of Type II facilities reported resident origins of 10 miles or under. In 1987, statistics were 33 percent, 37 percent and 34 percent, respectively.

Distance	Principally Retirement Centers	Nursing Care Oriented Facilities	Rental Facilities
UNDER 5 MILES	10%	16%	14%
5-10 MILES	33	27	20
11-15 MILES	17	30	29
16-20 MILES	12	7	13
21-25 MILES	9	13	12
OVER 25 MILES	19	13	12

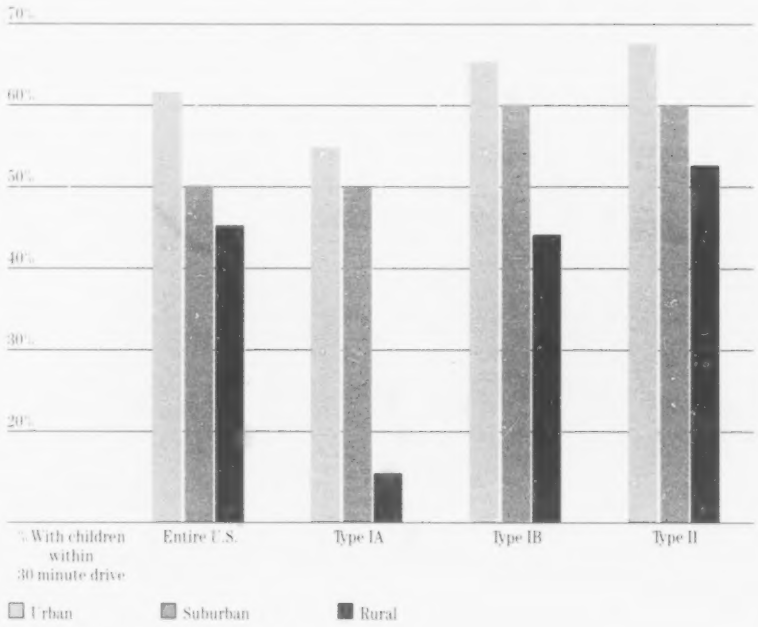
*All amounts are medians

*EXHIBIT II-3: Resident Proximity to Children by Facility Type**

Exhibit II-3 presents the median percentage of residents that have children living within a thirty-minute drive. While the majority of residents in all types of facilities live within thirty minutes of at least one of their children, residents of Type IA principally retirement centers were the least likely to live this close to their children. These statistics are consistent with the results of previous studies.

The following reveals agreement with the finding, as a higher percentage of Type IA principally retirement center residents come from out-of-state.

Mean Percentage of Residents Originating in the Same State as the Facility	
Entire U.S.	82.7%
Principally Retirement Centers	78.4%
Nursing Care Oriented Facilities	87.7%
Rental Facilities	85.0%

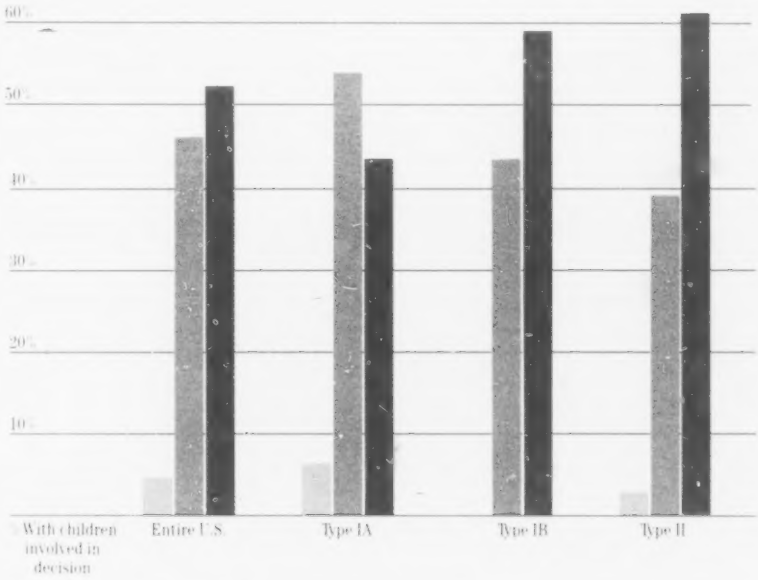


Type IA: Principally Retirement Centers
Type IB: Nursing Care Oriented Facilities
Type II: Rental Facilities

*All amounts are medians

*EXHIBIT II-4: Involvement of Children in Selection of Community by Facility Type**

Resident's children continue to play an important role in the decision to enter a retirement housing community. Only the category, "not involved at all," experienced a decrease between 1986 and 1987. The increase over 1986 statistics for resident's children's participation emphasizes the importance of their role. A possible explanation for the greater role of children may be an increasing average age of entry for residents (Exhibits III-7 and IV-7).



Type IA: Principally Retirement Centers
Type IB: Nursing Care Oriented Facilities
Type II: Rental Facilities

*All amounts are medians

EXHIBIT II-5: Marketing Techniques by Facility Type

Print media is the marketing instrument used most frequently by respondent facilities. Between 1986 and 1987, media usage changed very little, with a few exceptions. In 1986, community outreach programs were employed by 85 percent of the Type IA principally retirement facilities; in 1987 only 50 percent reported using these programs. Television advertising increased from 23.5 percent to 53 percent for Type IB nursing care oriented facilities and from 12 percent to 53 percent for Type II rental facilities, but dropped from 39.3 percent to 26 percent for Type IA communities. For all facility types, use of electronic media lags behind other marketing techniques.

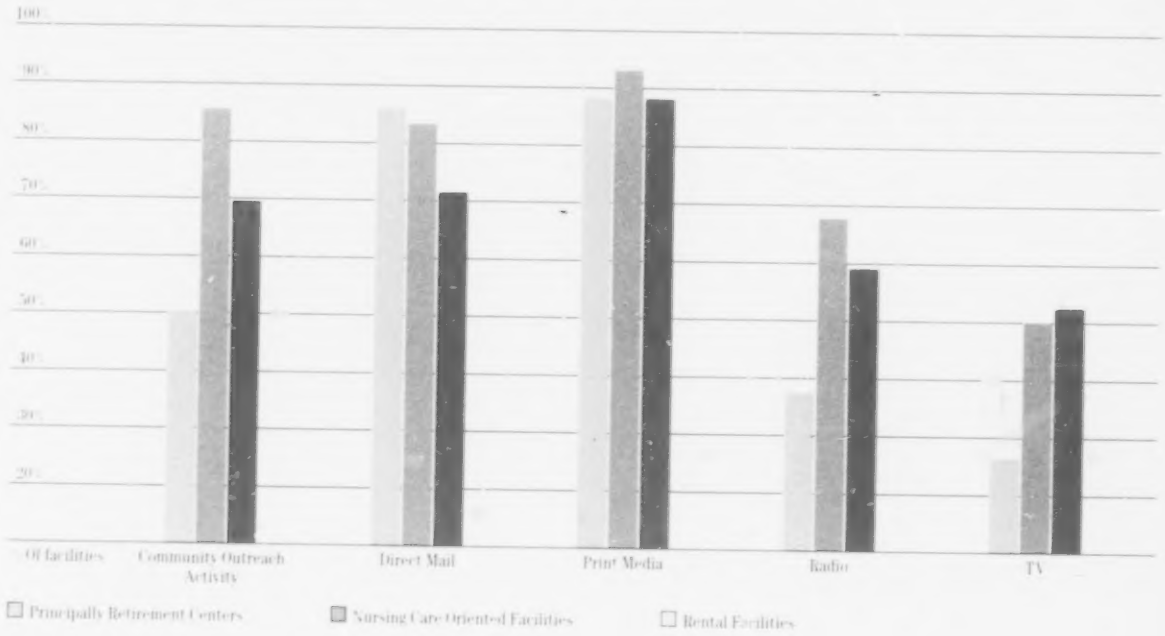


EXHIBIT II-6: Preconstruction Sales Results and Fill-up Time by Facility Type ***

Entrance fee facilities report greater preconstruction sales levels than rental facilities. A variety of factors contributes to this finding, including requirements established by underwriters and lenders, as well as state regulations that mandate a certain level of sales prior to construction for entrance fee facilities.

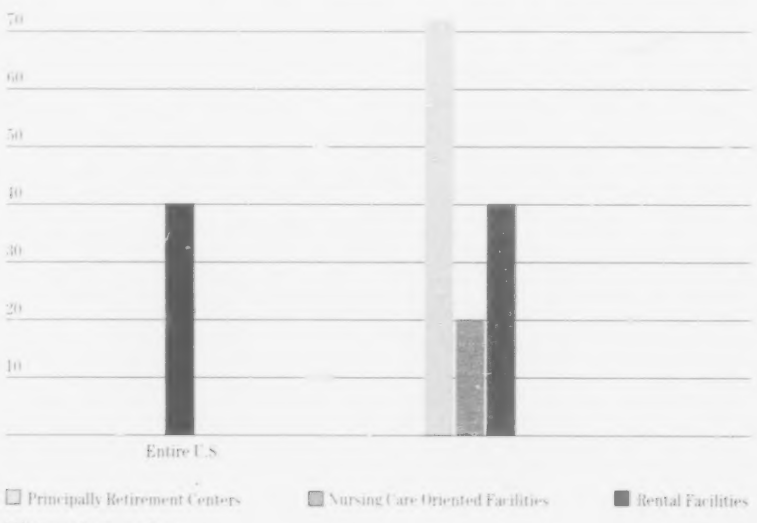
Perhaps as a result of increasing competition within the retirement housing industry, the median number of months to achieve 95 percent occupancy rose among all types of communities between the 1986 and 1987 surveys. Type II rental facilities experienced the most dramatic increase, from 12 to 24 months, while three and four month increases were experienced by Type IA principally retirement and Type IB nursing care oriented facilities, respectively.

	Principally Retirement Centers	Nursing Care Oriented Facilities	Rental Facilities
SALES ACHIEVED DURING PRECONSTRUCTION PERIOD	53%	60%	33%
UNITS FILLED DURING:			
0-6 Months of Occupancy	74	56	30
7-12 Months of Occupancy	18	40	20
13-18 Months of Occupancy	14	34	30
19-24 Months of Occupancy	6	51	15
NUMBER OF MONTHS REQUIRED TO ACHIEVE 95% OCCUPANCY	19	16	24

*All amounts are medians
**Information provided only for facilities built after 1977
Each item was individually tabulated

*EXHIBIT II-7: Number of Persons on Waiting List by Facility Type**

Waiting lists ranging from two through 1,200 persons were reported by 87 percent of respondents, with a median of 40 persons for the entire country. Fifty percent of all respondents indicated that they had plans for expansion within the next three years.



*All amounts are medians

*EXHIBIT II-8: Length of Waiting List by Unit Type by Facility Type and Age**

Unit Type	Principally Retirement Centers Built Before 1975	Principally Retirement Centers Built 1975 & Later	Nursing Care Oriented Facilities Built Before 1975	Nursing Care Oriented Facilities Built 1975 & Later	Rental Facilities Built Before 1975	Rental Facilities Built 1975 & Later
STUDIO	12.0 months	9.0 months	12.0 months	10.5 months	3.0 months	4.0 months
ONE-BEDROOM	18.0	9.0	12.0	7.5	10.5	5.0
TWO-BEDROOM	36.0	12.0	24.0	18.0	6.0	3.0
THREE-BEDROOM	72.0	24.0	13.0	**	19.5	4.5

*All amounts are medians
**Insufficient response

Exhibit II-8 provides information on the differences in the length of waiting lists based upon the type and age of the facility. Type II rental facilities have the shortest waiting lists. Many of the differences in waiting list length can be explained by the distribution of unit types in older and newer facilities (Exhibit I-7).

*EXHIBIT II-9: Vacancy Rates by Facility Type, Size and Age**

This year's study includes an analysis of the vacancy rates reported by respondent facilities. In nearly every case, rental facilities experienced the highest vacancy rates, while Type IA principally retirement centers generally experienced the lowest.

	Principally Retirement Centers	Nursing Care Oriented Facilities	Rental Facilities
ENTIRE U.S.	4.0%	5.0%	7.0%
SIZE:			
Under 150 Units	3.0	5.0	6.0
150 Units & Over	4.0	7.0	8.0
AGE:			
Built Before 1975	4.0	3.0	5.0
Built 1975 & Later	4.0	12.0	10.0

*All amounts are medians

*EXHIBIT II-10: Car Ownership by Residents by Facility Type and Location**

Interest in the percentage of residents maintaining automobiles is particularly high among developers, who often seek to reduce parking requirements of local zoning laws by assuming that many potential residents will not own cars.

The low percentage of rental residents owning automobiles can not be explained by urban location, given the relatively even distribution of car ownership in urban, suburban and rural areas. Nor is it completely explained by the provision of transportation services by rental facilities (Exhibit II-11). The lower percentage of car ownership among renters is probably due to their higher age and, perhaps, their lower socioeconomic status.

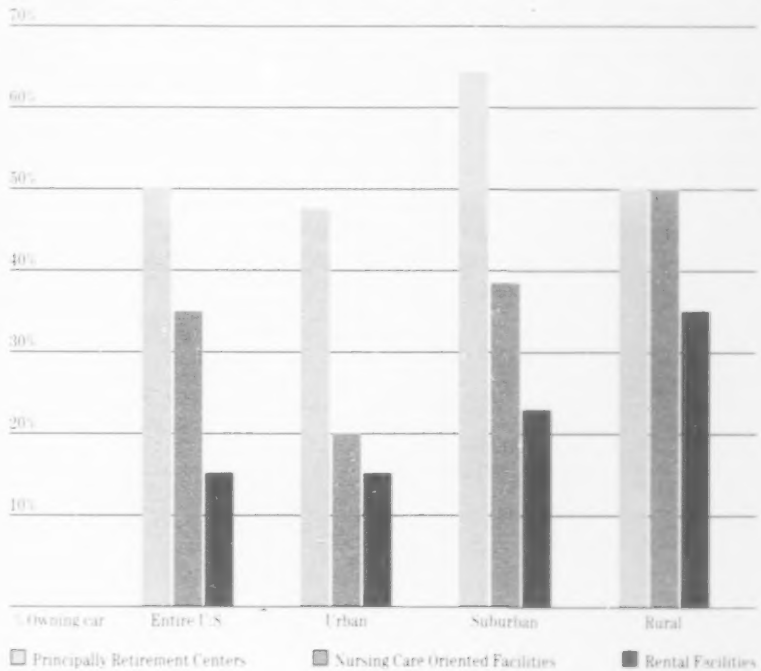


EXHIBIT II-11: Scheduled Transportation by Facility Type and Location

Most retirement housing facilities provide scheduled transportation; indeed all the rural Type IA principally retirement facilities provide transportation services. Interestingly, while car ownership is lowest among renters, Type II rental facilities are the least likely to provide transportation services.

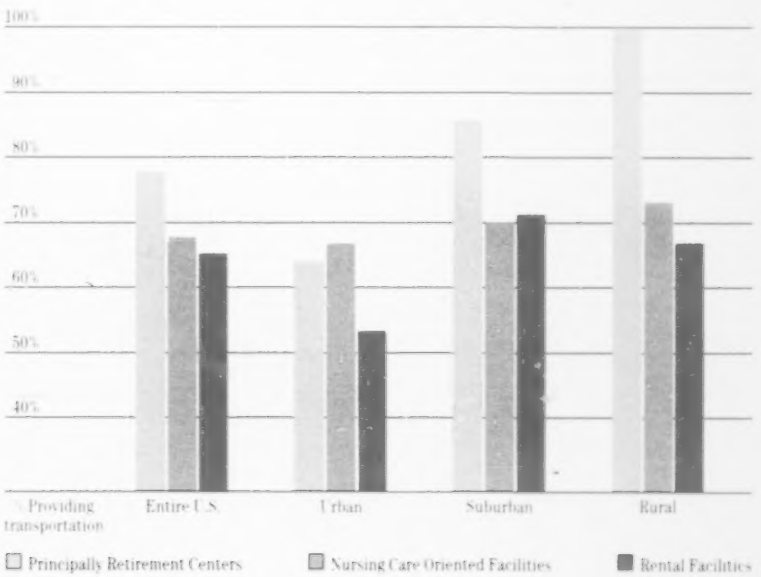


EXHIBIT II-12: Screening of Residents for Financial Capabilities by Facility Type

As would be expected, almost all potential residents of entrance fee facilities (Type IA and IB) are screened regarding their financial resources. Although the percentage is smaller than for entrance fee facilities, a large majority of rental facilities do screen residents.

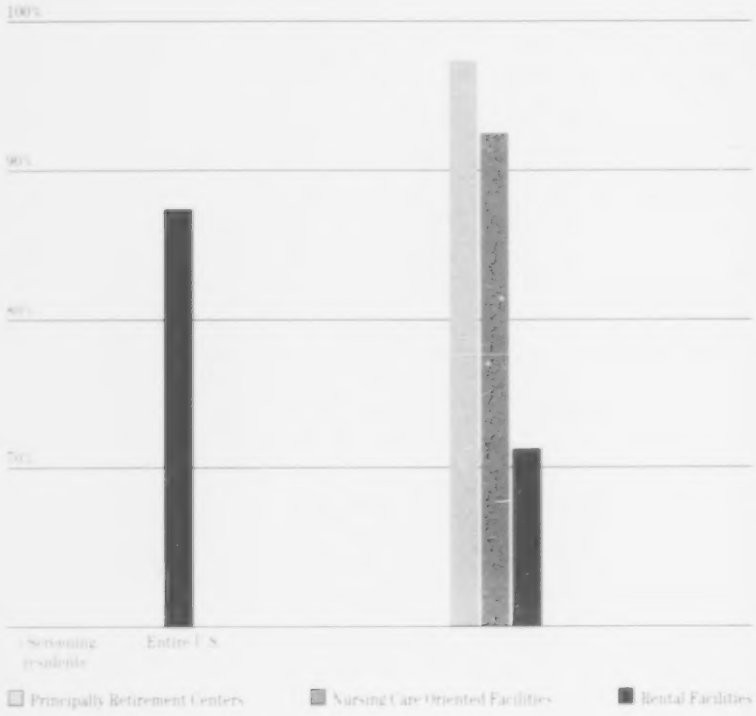
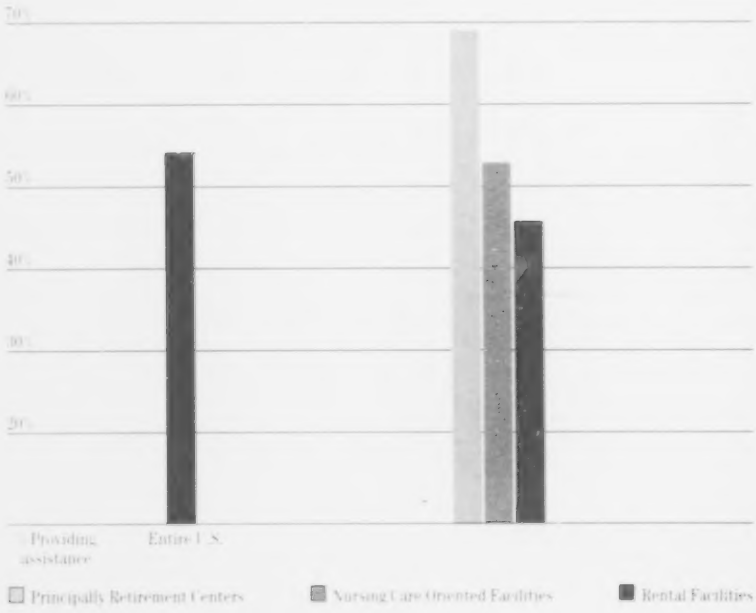


EXHIBIT II-13: Facilities Providing Financial Assistance by Facility Type

Respondent facilities were asked whether their resident contract provides financial assistance for residents, if necessary. As expected, entrance fee facilities (Type IA and IB) are more likely to provide this financial assistance, although the percentage of Type II rental facilities providing assistance increased over 1986 levels.



CHAPTER III: ENTRANCE FEE FACILITIES

Chapter III provides information on respondent facilities that charge entrance fees. These facilities have been divided into two groups, Type IA principally retirement centers and Type IB nursing care oriented facilities. As described in Exhibit I-2, this distinction is based upon the ratio of independent living units to nursing care beds.

SECTION A: PHYSICAL PLANT CHARACTERISTICS

EXHIBIT III-1: Acreage and Density

Not surprisingly, urban entrance fee facilities tend to be built on smaller campuses and have a greater number of apartment unit residents per acre when compared with their suburban and rural counterparts. However, Type IB nursing care oriented facilities appear to have somewhat larger campuses than Type IA principally retirement facilities, and are less densely populated. This lower density may result from the tendency of Type IB facilities to contain fewer units (Exhibits I-7 and III-2).

	Principally Retirement Centers			Nursing Care Oriented Facilities		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
ACREAGE:						
ENTIRE U.S.	8.0	19.5	45.0	15.3	29.0	59.8
LOCATION:						
Urban	4.0	13.0	22.3	5.0	16.0	30.0
Suburban	13.5	30.0	53.0	13.3	30.0	61.3
Rural	4.5	40.0	145.5	15.0	30.0	95.0
SIZE:						
Under 150 Units	2.0	4.0	7.0	16.0	29.0	57.8
150 units & Over	14.3	24.5	52.3	**	**	**
NUMBER OF APARTMENT RESIDENTS PER ACRE:						
ENTIRE U.S.	7.1	13.8	23.0	.9	2.7	5.5
LOCATION:						
Urban	13.4	19.2	33.2	2.0	4.2	7.7
Suburban	5.7	11.3	16.5	1.6	2.8	12.3
Rural	3.5	7.5	32.6	.2	1.0	5.4
SIZE:						
Under 150 Units	17.6	27.8	72.3	.7	2.6	5.3
150 Units & Over	6.2	13.2	19.4	**	**	**

**Insufficient response

EXHIBIT III-2: Square Footage: Entire U.S.

Consistent with past surveys, Type IA principally retirement centers tend to contain more units than Type IB nursing care oriented facilities. The greater square footage of the Type IA facilities can be attributed primarily to a greater number of units, rather than significantly larger units (Exhibit I-7).

	Entire U.S.		
	Lower Quartile	Median	Upper Quartile
PRINCIPALLY RETIREMENT CENTERS:			
TOTAL AREA OF:			
Apartment Complex	144,230	200,879	281,869
Nursing Center	15,388	21,168	32,256
Personal Care/ Assisted Living Center	6,936	13,780	20,500
Activities Center	18,112	31,854	47,030
UNIT TYPE:			
Studio	353	410	471
One-Bedroom	576	640	700
Two-Bedroom	832	925	1,044
Three-Bedroom	1,226	1,345	1,617
PERSONAL CARE ASSISTED LIVING:			
One-Bedroom Unit	404	564	679
Private Room	245	300	348
Semi-Private Room	315	360	462
NURSING CARE ORIENTED FACILITIES:			
TOTAL AREA OF:			
Apartment Complex	22,068	58,300	96,918
Nursing Center	23,450	32,000	52,450
Personal Care/ Assisted Living Center	4,925	14,250	36,704
Activities Center	6,848	14,640	34,000
UNIT TYPE:			
Studio	296	379	465
One-Bedroom	564	604	676
Two-Bedroom	780	945	1,176
Three-Bedroom	1,163	1,231	2,600
PERSONAL CARE ASSISTED LIVING:			
One-Bedroom Unit	379	560	594
Private Room	189	240	286
Semi-Private Room	242	370	525

*EXHIBIT III-3: Square Footage by Size and Age of Facility**

Apart from increasing total project square footage, the size of the facility has little effect on the size of individual units. Type IA principally retirement centers contain units that are slightly larger when the project has more than 150 units. Among Type IB nursing care oriented facilities, the reverse is true. Facilities built since 1975 tend to be larger overall, but no distinct trends are noted in the size of individual units based upon the age of the facility.

	Size		Age	
	Under 150 Units	150 Units & Over	Built Before 1975	Built 1975 & Later
PRINCIPALLY RETIREMENT CENTERS:				
Total Area of:				
Apartment Complex	55,128	228,215	164,000	236,610
Nursing Center	8,325	21,933	18,000	22,500
Personal Care-Assisted Living Center	2,735	14,200	10,598	15,920
Activities Center	10,000	32,850	26,665	36,400
UNIT TYPE:				
Studio	374	429	397	433
One-Bedroom	600	645	642	640
Two-Bedroom	905	938	1,000	906
Three-Bedroom	1,233	1,345	1,650	1,289
PERSONAL CARE-ASSISTED LIVING:				
One-Bedroom Unit	**	564	554	564
Private Room	225	306	265	316
Semi-Private Room	305	360	324	397
NURSING CARE ORIENTED FACILITIES:				
Total Area of:				
Apartment Complex	55,200	100,987	54,021	77,980
Nursing Center	30,045	46,116	29,535	32,957
Personal Care-Assisted Living Center	16,604	**	11,116	32,000
Activities Center	12,980	41,334	14,280	25,000
UNIT TYPE:				
Studio	384	345	353	412
One-Bedroom	610	564	608	602
Two-Bedroom	945	938	966	917
Three-Bedroom	1,200	1,261	1,200	1,261
PERSONAL CARE-ASSISTED LIVING:				
One-Bedroom Unit	560	563	560	248
Private Room	228	288	216	276
Semi-Private Room	435	225	336	350

*All amounts are medians
**Insufficient response

EXHIBIT III-4: Nursing Center Bed Analysis: Entire U.S.

As noted in Exhibit I-2, the number of nursing care beds per apartment unit provides the means for distinguishing between Type IA principally retirement centers and Type IB nursing care oriented facilities. Type IB facilities tend to have a similar number of apartments and nursing care beds. Several states have adopted regulations specifying that retirement communities build nursing beds at the ratio of four apartment units per bed. The median for Type IA principally retirement communities reflects the influence of this regulation.

	Entire U.S.		
	Lower Quartile	Median	Upper Quartile
PRINCIPALLY RETIREMENT CENTERS:			
Number of Beds per Facility	45.3	60.0	76.5
Number of Apartment Units per Bed	3.3	4.0	5.5
NURSING CARE ORIENTED FACILITIES:			
Number of Beds per Facility	69.0	93.5	190.0
Number of Apartment Units per Bed	1.0	1.2	1.7

*EXHIBIT III-5: Nursing Center Bed Analysis by Size and Age of Facility**

The ratio of apartment units per nursing care bed remains relatively stable among Type IA principally retirement centers, even after adjusting for size and age of the facilities. More variation is noted among the Type IB nursing care oriented facilities, where the newer facilities are including a greater number of apartments per nursing bed, following the trend toward more independent living arrangements.

	Size		Age	
	Under 150 Units	150 Units & Over	Built Before 1975	Built 1975 & Later
PRINCIPALLY RETIREMENT CENTERS:				
Number of Beds per Facility	25.5	61.0	54.0	60.5
Number of Apartment Units per Bed	3.9	4.0	4.0	3.9
NURSING CARE ORIENTED FACILITIES:				
Number of Beds per Facility	86.7	168.5	90.0	95.9
Number of Apartment Units per Bed	.8	1.3	1.0	.9

*All amounts are medians

SECTION B: RESIDENT CHARACTERISTICS

EXHIBIT III-6: Gender of Residents

It is widely known that women have a longer life span than men, resulting in a larger number of elderly widows. The data reported by respondent facilities about the gender breakdown of their residents reflect this statistic. Facilities reported data about resident gender for the last three years. Although slight, there appears to be a trend toward a greater number of men in both types of entrance fee facilities. While the sheer number of elderly widows will continue to be reflected in this statistic, the small increase in the percentage of males may be the result of an increased number of married couples entering projects and an increase in the appeal of projects to elderly widowers, who have traditionally received care from a daughter or daughter-in-law.

	Median		Range	
	Female	Male	Female	Male
PRINCIPALLY RETIREMENT CENTERS:				
1986	77.4%	22.6%	52.9-95.5%	4.5-47.1%
1985	77.5	22.5	58.7-89.7	10.3-41.3
1984	78.0	22.0	10.3-39.4	60.4-89.7
NURSING CARE ORIENTED FACILITIES:				
1986	74.8%	25.2%	49.7-91.6%	8.4-50.3%
1985	77.0	23.0	49.6-91.8	8.2-50.4
1984	75.8	24.2	49.6-92.8	7.3-50.4

*EXHIBIT III-7: Average Age of Residents**

Consistent with the results of previous studies, the average resident entering a retirement facility is nearly 80 years old. No significant difference exists between the two types of entrance fee facilities concerning age of residents or entry age. Also, examining the age of the facility yields no significant impact.

	Average Age at Entry to Apartments During the Last Three Years		Average Age of All Residents 1986	
	Female	Male	Female	Male
PRINCIPALLY RETIREMENT CENTERS:				
ENTIRE U.S.	78.0	78.0	81.0	81.5
AGE:				
Built Before 1975	78.0	78.0	82.0	82.0
Built 1975 & Later	81.0	78.0	81.0	78.0
NURSING CARE ORIENTED FACILITIES:				
Entire U.S.	79.0	79.0	82.0	81.5
AGE:				
Built Before 1975	79.0	79.0	82.0	81.5
Built 1975 & Later	79.0	79.0	82.0	82.0

*All amounts are medians

*EXHIBIT III-8: Annual Apartment Turnover per 100 Residents**

Exhibit III-8 reports the median rates of death and transfer for males and females per 100 apartment units. The combined turnover column adjusts the total turnover rates for the reported percentage of females and males (Exhibit III-6). The combined total column reports the adjusted turnover rates and includes voluntary transfers.

	Deaths		Permanent Transfers to Nursing Center		Permanent Transfers to Personal Care/Assisted Living		Total Turnover		Combined Turnover	Combined Total[1]
	Female	Male	Female	Male	Female	Male	Female	Male	Total	Total
PRINCIPALLY RETIREMENT CENTERS:										
BUILT BEFORE 1975										
1986	5.2	8.6	4.5	4.0	2.5	2.5	10.2	13.3	11.3	12.3
1985	4.7	9.8	4.1	4.5	1.6	1.8	9.8	12.0	11.4	12.3
1984	4.8	8.4	4.7	6.0	2.7	**	10.3	10.0	10.2	11.8
BUILT 1975 & LATER										
1986	3.7	11.7	3.5	4.4	2.2	2.2	8.7	13.8	9.7	10.9
1985	4.1	8.4	4.3	6.0	3.6	4.8	8.5	16.3	11.1	11.9
1984	3.4	6.2	3.3	4.4	3.5	4.9	8.4	12.5	9.2	10.5
NURSING CARE ORIENTED FACILITIES:										
BUILT BEFORE 1975[2]										
1986	4.8	11.1	7.9	11.4	2.6	6.1	10.5	19.1	12.1	13.8
1985	4.0	11.5	6.6	11.1	5.3	5.6	11.3	12.5	11.4	11.8
1984	2.9	4.6	7.2	9.1	6.0	8.2	8.4	8.9	8.5	9.1

*All amounts are medians
Each item was individually tabulated
**Insufficient response
(1) Combined total includes all voluntary withdrawals
(2) Insufficient response from nursing care oriented facilities built 1975 & later

EXHIBIT III-9: Patient Days in Nursing Center for Former Apartment Residents

Exhibit III-9 presents information on the number of patient days spent in a facility's nursing home by former apartment residents. These days have been divided into: temporary, the resident returned to his apartment, and permanent, the resident is not expected to return to his former housing. This year, for the first time, data is reported for both types of entrance fee facilities.

The theoretical number of nursing beds occupied by former retirement facility residents in a community with 250 residents is determined by multiplying the number of patient days per resident per year by 250 residents, then dividing the results by 365. For example, using this analysis on any particular day, a theoretical facility of 250 residents built before 1975 has a median of 5.5 beds filled by temporary transfers to the nursing center and 30.1 beds filled by permanent transfers.

	Lower Quartile	Median	Upper Quartile
PRINCIPALLY RETIREMENT CENTERS:			
PATIENT DAYS PER APARTMENT RESIDENT PER YEAR:			
TEMPORARY:			
Built Before 1975	2.0	8.0	13.0
Built 1975 & Later	5.0	7.0	13.0
PERMANENT:			
Built Before 1975	33.0	44.0	58.0
Built 1975 & Later	19.0	35.0	56.0
NUMBER OF BEDS OCCUPIED PER DAY IN NURSING CARE CENTER FOR A FACILITY WITH 250 APARTMENT RESIDENTS:			
TEMPORARY:			
Built Before 1975	1.4	5.5	8.9
Built 1975 & Later	3.4	4.8	8.9
PERMANENT:			
Built Before 1975	22.6	30.1	39.7
Built 1975 & Later	13.0	17.1	38.4
NURSING CARE ORIENTED FACILITIES(1):			
PATIENT DAYS PER APARTMENT RESIDENT PER YEAR:			
TEMPORARY:			
Built Before 1975	4.0	19.0	39.0
PERMANENT:			
Built Before 1975	62.0	91.0	176.0
NUMBER OF BEDS OCCUPIED PER DAY IN NURSING CARE CENTER FOR A FACILITY WITH 250 APARTMENT RESIDENTS:			
TEMPORARY:			
Built Before 1975	2.7	13.0	26.7
PERMANENT:			
Built Before 1975	42.5	62.3	120.5

(1) Insufficient response from nursing care oriented facilities built in 1975 & later

SECTION C: REVENUES

EXHIBIT III-10: Nursing Center Daily Rates

Respondent facilities reported the daily room rates charged for skilled and intermediate nursing care services. These rates reflect the actual charges for private and semi-private rooms, before any discounts for retirement community residents are applied.

	Private Room			Semi-Private Room		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
PRINCIPALLY RETIREMENT CENTERS:						
Skilled Care	$84	$96	$120	$67	$70	$82
Intermediate Care	73	94	100	52	69	85
NURSING CARE ORIENTED FACILITIES:						
Skilled Care	$60	$84	$ 94	$55	$67	$75
Intermediate Care	50	65	80	46	57	67

EXHIBIT III-11: Rate Increases*

After remaining constant at 5 percent for several years, the median rate increase for monthly fees for Type IA principally retirement communities climbed to 8 percent. Despite attempts by communities to screen residents for financial capabilities (Exhibit II-12), significant increases in monthly fees may be difficult for some residents with relatively fixed incomes to afford. This may, in part, explain the increasing percentage of Type IA residents who may eventually require financial assistance (Exhibit III-21).

	Increase in Apartment Rates	Increase in Nursing Care Rates
PRINCIPALLY RETIREMENT CENTERS:		
1986	8.0%	5.5%
1985	5.0	6.0
1984	5.0	6.0
NURSING CARE ORIENTED FACILITIES:		
1986	6.0%	5.0%
1985	5.0	5.0
1984	5.0	5.0

*All amounts are medians

The Banker's Table

William Michael Harnett (1848-1892)

The Metropolitan Museum of Art,

Elihu Root, Jr., Gift, 1956. (56.24)

Financing

The world of financing is never static. In the retirement housing field, as the options available to developers continue to change, the means by which an organization funds a new facility can be as individual as the project itself.

Perhaps the greatest challenge facing retirement housing projects in the area of finance is the formation of capital. Educating the financial community about the nuances involved with building, owning, operating, and managing a retirement community will enable prospective lenders and investors to better understand the project's possibilities and gain a greater appreciation of the overall potential of the industry. Even a significant amount of education, however, is unlikely to overcome resistance to funding an inexperienced development team. It is essential to present a strong organizational structure consisting of a quality development, management and marketing team to potential financiers.

Financing a retirement housing facility can be accomplished in many ways. Among the options are taxable bonds, tax-exempt bond issues, commercial loans, syndication and various types of partnerships. Selecting from these choices and putting together a creative financing package can help to meet the challenges of the project.

EXHIBIT III-12: Entrance Fees by Selected Criteria

Exhibit III-12 depicts the wide range of entrance fees charged by facilities. In every case, Type IA principally retirement communities report higher entrance fees than the Type IB nursing care oriented facilities. Consistent with the results of previous years, suburban facilities tend to have the highest entrance fees. For Type IA and Type iB facilities, newer and larger projects generally have higher entrance fees.

Variations in entrance fees relate to the age of the facility, size of units, type of health care offered, geographic location, the project construction costs, entrance fee refundability and various other factors. We hope that as the number of respondents increases, future editions of this study will examine the effects of these factors on entrance fees.

	One Person					
	Studio			One Bedroom		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
PRINCIPALLY RETIREMENT CENTERS:						
ENTIRE U.S.	$23,000	$33,300	$43,188	$39,545	$55,000	$68,500
LOCATION:						
Urban	23,000	31,175	39,138	38,000	52,000	59,488
Suburban	17,325	38,500	47,475	40,450	63,500	72,000
Rural	**	28,000	**	**	50,000	**
AGE:						
Built Before 1975	17,200	24,250	36,515	37,520	44,462	62,788
Built 1975 & Later	26,700	39,000	48,608	45,000	57,900	70,500
SIZE:						
Under 150 Units	13,838	18,650	35,475	25,825	40,000	52,750
150 Units & Over	24,600	36,515	45,900	41,881	57,900	72,000
NURSING CARE ORIENTED FACILITIES:						
ENTIRE U.S.	$10,000	$24,425	$34,000	$22,975	$36,850	$53,600
LOCATION:						
Urban	4,550	10,000	27,375	13,000	28,000	34,600
Suburban	20,913	33,125	38,688	36,563	52,400	70,000
Rural	18,875	29,250	3[illegible]	25,475	38,250	57,500
AGE:						
Built Before 1975	10,000	18,500	33,250	20,375	35,000	53,100
Built 1975 & Later	20,000	33,000	35,000	33,963	41,700	56,750
SIZE:						
Under 150 Units	8,875	21,550	34,000	20,375	36,850	54,500
150 Units & Over	14,275	26,125	34,500	27,500	37,370	51,825

**Insufficient response

One Person						Additional Fee Second Person	
	Two Bedroom			Three Bedroom			
Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	One Bedroom Median	Two Bedroom Median
$50,063	$75,300	$88,225	$76,250	$110,250	$125,175	$ 7,500	$ 7,500
48,500	71,300	82,874	45,500	89,000	118,900	7,600	4,000
50,250	80,000	90,000	98,625	110,250	124,750	7,500	7,500
**	63,100	**	**	**	**	**	**
46,170	62,754	88,104	70,000	89,000	181,900	8,000	8,540
54,910	78,049	88,225	106,500	110,500	124,000	4,816	6,000
45,000	50,000	75,750	**	79,000	**	2,000	2,000
61,444	79,750	89,200	90,750	110,500	127,475	7,800	7,500
$31,700	$54,450	$70,750	**	$ 79,000	**	$ 2,000	$ 2,000
5,000	45,000	55,000	71,800	90,000	110,000	3,500	4,000
49,838	65,500	$1,375	71,200	103,000	122,000	2,000	2,000
31,700	54,450	$1,925	**	**	**	**	**
21,450	52,550	69,625	71,200	110,000	122,000	3,500	3,500
47,750	63,800	75,000	71,800	87,400	103,000	10,000	12,000
30,000	55,000	71,000	110,000	116,000	122,000	2,000	2,750
12,500	53,775	72,500	71,200	71,800	103,000	12,000	14,000

EXHIBIT III-13: Monthly Fees by Selected Criteria

Monthly fees charged by the two types of entrance fee facilities do not exhibit the same trends as the entrance fees. Monthly fees for Type IA principally retirement facilities are higher for urban facilities, and no consistent trends are noted after adjusting for size and age.

Variations in monthly fees are due to many factors including the type of meal service, the frequency of meals and housekeeping services, inclusion of utilities and the type of health care included in the monthly fee. Future editions of the study will profile the standard service and amenity package being offered by these facilities.

	One Person					
	Studio			One-Bedroom		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
PRINCIPALLY RETIREMENT CENTERS:						
ENTIRE U.S.	$549	$608	$734	$641	$740	$ 910
LOCATION:						
Urban	533	669	805	691	805	1,008
Suburban	575	597	696	582	641	904
Rural	**	541	**	**	740	**
AGE:						
Built Before 1975	460	657	764	562	805	940
Built 1975 & Later	560	597	734	641	693	884
SIZE:						
Under 150 Units	521	650	713	681	765	910
150 Units & Over	552	598	746	621	702	909
NURSING CARE ORIENTED FACILITIES:						
ENTIRE U.S.	$440	$603	$902	$296	$600	$ 898
LOCATION:						
Urban	443	750	967	486	725	900
Suburban	542	603	807	272	624	1,370
Rural	308	591	910	150	296	711
AGE:						
Built Before 1975	530	652	935	269	624	896
Built 1975 & Later	427	492	760	330	594	1,134
SIZE:						
Under 150 Units	407	580	724	292	592	896
150 Units & Over	502	680	887	599	850	1,212

**Insufficient response

One Person						Additional Fee Second Person	
Two-Bedroom			Three-Bedroom				
Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	One-Bedroom Median	Two-Bedroom Median
$727	$802	$1,146	$ 764	$ 807	$1,307	$391	$389
741	955	1,279	742	1,412	2,980	319	311
626	727	1,027	764	764	1,195	416	429
**	845	**	**	**	**	**	**
581	840	1,123	614	1,412	2,980	324	305
727	774	1,149	764	764	1,195	259	262
400	867	1,020	949	949	949	310	274
727	774	1,169	764	764	1,307	394	513
$302	$666	$1,044	$ 920	$1,588	$2,733	$300	$217
680	752	890	890	950	1,010	600	492
246	699	1,611	1,588	1,687	3,135	250	248
150	332	781	**	**	**	251	217
244	652	874	890	1,588	3,135	449	446
412	810	1,391	1,010	1,349	1,687	165	118
300	617	800	890	2,013	3,135	217	200
297	846	1,374	1,010	1,588	1,687	308	340

SECTION D: EXPENSES

EXHIBIT III-14: Salary Information: Entire U.S.

Exhibit III-14 depicts similarities in the salary structure at both types of entrance fee facilities. The most significant difference is noted for the administrator position, where Type IA executives earn more than their Type IB counterparts. This has been true in previous years and may be due to the tendency of Type IA facilities to be larger (Exhibit I-7).

	Entire U.S.		
	Lower Quartile	Median	Upper Quartile
PRINCIPALLY RETIREMENT CENTERS:			
SALARY PER PERSON FOR:			
Executive Director or Administrator	$36,000	$47,500	$60,000
Assistant Executive Director	26,505	34,000	46,900
Controller	23,637	30,000	38,165
Administrative (Excluding Nursing)	10,528	13,802	17,018
Nursing Center Administrator	24,110	29,250	34,797
Administrative (Nursing)	13,067	15,915	24,400
Nursing Staff	10,095	12,080	15,262
Personal Care Staff	9,336	11,485	16,165
Dietary	7,857	9,379	10,640
Housekeeping & Laundry	8,360	9,487	11,241
Maintenance	11,514	16,000	17,820
Social Activities	12,500	14,667	16,825
Vehicle Drivers	8,389	11,200	14,027
Security	8,133	10,215	13,098
NURSING CARE ORIENTED FACILITIES:			
SALARY PER PERSON FOR:			
Executive Director or Administrator	$29,550	$42,000	$49,138
Assistant Executive Director	28,370	36,225	39,602
Controller	27,199	32,063	37,570
Administrative (Excluding Nursing)	10,962	13,132	19,140
Nursing Center Administrator	23,626	28,000	30,982
Administrative (Nursing)	13,452	18,222	20,249
Nursing Staff	10,475	12,382	16,667
Personal Care Staff	7,312	12,011	14,708
Dietary	8,689	10,411	11,955
Housekeeping & Laundry	8,504	9,880	11,798
Maintenance	12,674	14,940	17,993
Social Activities	10,456	13,200	17,392
Vehicle Drivers	5,244	11,000	12,450
Security	10,270	11,577	12,992

*EXHIBIT III-15: Salary Information by Size of Facility**

Although not universally true, median salaries for Type IA principally retirement communities tend to be higher for the larger facilities. Type IB nursing care oriented facilities do not exhibit a clear trend., although salaries for executives of larger facilities are similar to their counterparts at larger Type IA facilities.

	Size	
	Under 150 Units	150 Units & Over
PRINCIPALLY RETIREMENT CENTERS:		
SALARY PER PERSON FOR:		
Executive Director or Administrator	$30,000	$51,178
Assistant Executive Director	15,200	34,051
Controller	14,560	30,000
Administrative (Excluding Nursing)	13,850	13,729
Nursing Center Administrator	**	30,000
Administrative (Nursing)	14,000	16,814
Nursing Staff	11,266	12,090
Personal Care Staff	10,333	11,060
Dietary	9,000	9,389
Housekeeping & Laundry	10,377	9,437
Maintenance	11,600	16,004
Social Activities	14,000	14,667
Vehicle Drivers	8,840	11,550
Security	7,120	10,932
NURSING CARE ORIENTED FACILITIES:		
SALARY PER PERSON FOR:		
Executive Director or Administrator	$40,070	$49,350
Assistant Executive Director	36,000	38,392
Controller	30,400	36,023
Administrative (Excluding Nursing)	13,000	16,265
Nursing Center Administrator	27,868	29,198
Administrative (Nursing)	19,000	13,133
Nursing Staff	12,382	15,402
Personal Care Staff	12,011	**
Dietary	10,414	10,552
Housekeeping & Laundry	9,747	8,889
Maintenance	15,806	11,953
Social Activities	14,000	9,200
Vehicle Drivers	11,000	4,385
Security	10,924	10,667

*All amounts are medians
**Insufficient response

*EXHIBIT III-16: Salary Information by Location of Facility**

Exhibit III-16 provides another analysis of salaries for entrance fee facilities, based upon urban, rural and suburban locations. In most cases, differences in median salaries based upon location are not as significant as differences based upon facility size.

	Location		
	Urban	Suburban	Rural
PRINCIPALLY RETIREMENT CENTERS:			
SALARY PER PERSON FOR:			
Executive Director or Administrator	$48,616	$47,328	**
Assistant Executive Director	34,051	32,650	**
Controller	37,036	27,405	**
Administrative (Excluding Nursing)	14,533	12,464	**
Nursing Center Administrator	32,000	25,800	**
Administrative (Nursing)	18,600	15,915	**
Nursing Staff	11,804	12,099	**
Personal Care Staff	11,287	11,333	**
Dietary	9,368	9,883	**
Housekeeping & Laundry	8,866	10,537	**
Maintenance	15,755	16,656	**
Social Activities	14,617	14,599	**
Vehicle Drivers	9,339	12,760	**
Security	10,718	9,927	**
NURSING CARE ORIENTED FACILITIES:			
SALARY PER PERSON FOR:			
Executive Director or Administrator	$40,070	$28,000	$37,000
Assistant Executive Director	36,000	**	**
Controller	22,000	**	**
Administrative (Excluding Nursing)	11,629	13,132	16,409
Nursing Center Administrator	26,636	**	25,142
Administrative (Nursing)	19,749	17,316	18,140
Nursing Staff	11,630	17,028	12,721
Personal Care Staff	13,173	**	10,826
Dietary	9,522	11,700	9,499
Housekeeping & Laundry	9,461	11,173	9,973
Maintenance	14,410	14,684	16,846
Social Activities	14,061	13,200	13,466
Vehicle Drivers	11,333	**	7,392
Security	10,667	**	**

*All amounts are medians
**Insufficient response

EXHIBIT III-17: Number of Employees: Entire U.S.

Although Type IA principally retirement centers tend to be larger than the Type IB nursing care oriented facilities, staffing patterns are similar. The one exception is found in the number of nursing staff, which can be explained by larger on-site nursing homes of Type IB facilities.

	Entire U.S.		
	Lower Quartile	Median	Upper Quartile
PRINCIPALLY RETIREMENT CENTERS:			
Executive Director or Administrator	1.0	1.0	1.0
Assistant Executive Director	1.0	1.0	1.0
Controller	1.0	1.0	1.0
Administrative (Excluding Nursing)	2.0	4.0	7.0
Nursing Center Administrator	1.0	1.0	1.0
Administrative (Nursing)	1.3	2.0	3.8
Nursing Staff	15.0	26.0	40.0
Personal Care Staff	2.0	4.0	7.0
Dietary	11.3	15.5	24.8
Housekeeping & Laundry	7.3	12.0	20.0
Maintenance	3.0	5.0	8.0
Social Activities	1.0	2.0	3.0
Vehicle Drivers	1.0	1.0	2.0
Security	2.0	3.5	5.0
NURSING CARE ORIENTED FACILITIES:			
Executive Director or Administrator	1.0	1.0	1.0
Assistant Executive Director	1.0	1.0	1.0
Controller	1.0	1.0	1.0
Administrative (Excluding Nursing)	3.0	4.5	14.8
Nursing Center Administrator	1.0	1.0	1.0
Administrative (Nursing)	2.0	2.5	6.8
Nursing Staff	22.0	40.0	63.0
Personal Care Staff	3.0	5.0	6.8
Dietary	8.3	15.5	24.0
Housekeeping & Laundry	5.3	13.0	19.5
Maintenance	2.3	5.0	8.0
Social Activities	2.0	2.0	4.0
Vehicle Drivers	1.0	1.0	2.0
Security	1.0	2.0	4.5

EXHIBIT III-18: Payroll Expense Statistics

Differences in the costs of the dietary payroll per meal result from variations in the type of meal service provided to residents—menu/waitress service, family style/modified waitress service or cafeteria service. To a certain extent these differences also reflect variations in staffing patterns and the ability to use part-time employees during peak hours. In subsequent surveys, greater attempts will be made to distinguish among meal plans when analyzing this statistic.

Given the similarities in the staffing patterns between both types of entrance fee facilities and the greater size of the Type IA facilities (Exhibit III-2), it follows that there will be the greater area per housekeeper and maintenance employee reported by Type IA facilities.

	Principally Retirement Centers			Nursing Care Oriented Facilities		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
DIETARY DEPARTMENT:						
Dietary Payroll Per Meal	$1.13	$1.43	$1.87	$.99	$1.27	$1.92
HOUSEKEEPING AND MAINTENANCE DEPARTMENTS:						
Housekeeping Payroll Per Square Foot of Entire Facility	.42	.57	.80	.79	1.05	1.67
Maintenance Payroll Per Square Foot of Entire Facility	.26	.35	.62	.46	.60	.95
Square Feet Per Housekeeper	12,758	18,525	29,878	7,745	9,553	17,917
Square Feet Per Maintenance Employee	26,639	43,707	71,200	21,413	28,800	33,526

EXHIBIT III-19: Expense Statistics

Some variation in the expense statistics in Exhibit III-19 is created by differences in the level of service provided by retirement facilities. Diversity in the types and quality of menus and food costs contribute to the reported variations in raw food cost. Whether or not residents pay for utilities in monthly fees affects utility costs per square foot. The type of building construction, geographic location and the efficiency of heating, ventilation and air-conditioning systems also have an impact on utility costs.

Food service management companies are retained by approximately 20 percent of the respondent facilities. The cost per meal charged by these companies is also reported in Exhibit III-19.

	Entire U.S.			Size*	
	Lower Quartile	Median	Upper Quartile	Under 150 Units	150 Units & Over
PRINCIPALLY RETIREMENT CENTERS:					
Raw Food Cost Per Meal	$1.30	$1.57	$2.10	$1.49	$1.66
Utilities Expense Per Square Foot	.91	1.14	1.29	1.14	1.16
Cost of Food Management Service Per Meal	.18	.25	.34	.25	.26
NURSING CARE ORIENTED FACILITIES:					
Raw Food Cost Per Meal	$ .92	$1.23	$1.55	$1.19	$1.26
Utilities Expense Per Square Foot	.88	1.33	1.78	1.42	1.28
Cost of Food Management Service Per Meal	.05	.13	.36	.15	.12

*All amounts are medians

EXHIBIT III-20: Reserve Funds

Respondents were asked to report funds that were being held as reserves other than for debt service or mortgage repayment. As compared with the 1986 survey, reserves, in total and the amount per resident, are higher. This may reflect the type of financing arrangements and debt covenants, as well as reserves to provide guaranteed health care to residents. The higher reserves reported in this year's survey may also reflect the increased expectations of Type IA principally retirement center administrators about the number of residents who will eventually require financial assistance (Exhibit III-21).

	Principally Retirement Centers			Nursing Care Oriented Facilities		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
TOTAL AMOUNT OF ALL RESERVES	$342,084	$1,280,095	$4,021,485	$216,314	$1,424,307	$4,605,371
TOTAL RESERVES PER RESIDENT	2,240	$1,118,712	25,903	1,871	9,708	28,085

EXHIBIT III-21: Financial Assistance for Principally Retirement Centers: Entire U.S.

When compared with the 1986 study, increases were reported by Type IA principally retirement centers for residents who currently require financial assistance and those residents who will eventually require assistance.

Residents Currently Requiring Financial Assistance		Current Residents Who Will Require Assistance	
Lower Quartile	3.0	Lower Quartile	4.0
Median	5.5	Median	10.0
Upper Quartile	11.8	Upper Quartile	20.0

CHAPTER IV: RENTAL FACILITIES

Chapter IV presents data for retirement facilities that do not charge entrance fees. These Type II rental communities were distinguished from entrance fee facilities in Exhibit I-2. While some rental facilities reported an "entrance fee," this figure was typically equal or double the monthly fee, and was considered a security deposit for the purpose of this study.

SECTION A: PHYSICAL PLANT CHARACTERISTICS

EXHIBIT IV-1: Acreage and Density

Rental facilities typically have less land and acreage than their entrance fee counterparts, as reported in Exhibit III-1. This statistic is particularly noticeable among the urban rental facilities, which far exceed the density of the entrance fee facilities.

	Rental Facilities		
	Lower Quartile	Median	Upper Quartile
ACREAGE:			
ENTIRE U.S.	4.0	7.0	30.0
LOCATION:			
Urban	2.0	3.0	5.8
Suburban	5.0	10.0	31.8
Rural	4.5	30.0	46.0
SIZE OF FACILITY:			
Under 150 Units	3.0	6.0	15.0
150 Units & Over	6.3	22.5	56.0
NUMBER OF APARTMENT RESIDENTS PER ACRE:			
ENTIRE U.S.	6.1	12.3	28.4
LOCATION:			
Urban	18.0	27.5	44.2
Suburban	6.1	10.7	19.6
Rural	1.2	3.5	31.2
SIZE:			
Under 150 Units	3.9	12.2	30.6
150 Units & Over	6.3	10.9	27.2

EXHIBIT IV-2: Square Footage: Entire U.S.

The median square footage for rental communities lies between that of the two types of entrance fee projects (Exhibit III-2). Almost 50 percent of the rental communities reported on-site nursing homes and nearly 25 percent reported having personal care assisted living units (Exhibit I-6).

	Entire U.S.		
	Lower Quartile	Median	Upper Quartile
RENTAL FACILITIES:			
Apartment Complex	33,360	75,189	150,000
Nursing Center	6,325	15,155	29,446
Personal Care Assisted Living Center	4,813	11,302	21,607
Activities Center	6,000	17,260	44,600
UNIT TYPE:			
Studio	299	370	429
One Bedroom	528	576	658
Two Bedroom	703	850	1,000
Three Bedroom	860	1,280	1,588
PERSONAL CARE ASSISTED LIVING:			
One Bedroom Unit	248	420	654
Private Room	186	338	670

*EXHIBIT IV-3: Square Footage by Size and Age of Facility**

Like Type IA principally retirement centers, rental facilities containing the most number of units tend to have larger individual units (Exhibit III-3).

	Size	
	Under 150 Units	150 Units & Over
RENTAL FACILITIES:		
Apartment Complex	45,573	187,981
Nursing Center	15,225	21,377
Personal Care Assisted Living Center	7,600	22,142
Activities Center	13,847	24,742
UNIT TYPE:		
Studio	346	419
One Bedroom	578	625
Two Bedroom	740	974
Three Bedroom	940	1,400
PERSONAL CARE ASSISTED LIVING:		
One Bedroom Unit	262	602
Private Room	250	420

*All amounts are medians

EXHIBIT IV-4: Nursing Center Bed Analysis: Entire U.S.

For rental facilities that have on-site nursing centers, the median number of beds is 65, comparable with the size of the Type IA principally retirement centers' nursing centers. The median ratio of apartment units per bed for rental communities with nursing homes, however, displays greater similarity to Type IB nursing care oriented facilities (Exhibit III-4).

	Entire U.S.		
	Lower Quartile	Median	Upper Quartile
RENTAL FACILITIES:			
Number of Beds per Facility	47.5	65.0	130.8
Number of Apartment Units per Bed	.9	1.7	3.2

*EXHIBIT IV-5: Nursing Center Bed Analysis by Size and Age of Facility**

Exhibit IV-5 provides further information about rental communities with nursing care units. While the median size of the unit does not vary based upon the size or age of the facility, larger and newer rental communities support a greater number of apartment units per bed.

	Size		Age	
	Under 150 Units	150 Units & Over	Built Before 1975	Built 1975 & Later
RENTAL FACILITIES:				
Number of Beds per Facility	66.5	65.0	65.0	67.0
Number of Apartment Units per Bed	1.2	1.5	1.3	2.4

* All amounts are medians

SECTION B: RESIDENT CHARACTERISTICS

EXHIBIT IV-6: Gender of Residents

The slight upward trend among entrance fee facilities toward a greater percentage of male residents, as shown in Exhibit III-6, is not consistently true for rental facilities. However, the percentage of males and females is remarkably consistent among all facilities. In order to better gauge this trend, future editions of the study will ask questions about the marital status of residents upon entering a retirement housing facility.

	Median		Range	
	Female	Male	Female	Male
RENTAL FACILITIES:				
1986	75.8	24.2	50.0-90.0	10.0-50.0
1985	78.5	21.5	60.0-92.8	7.2-40.0
1984	77.9	22.1	57.9-91.4	8.6-42.1

*EXHIBIT IV-7: Average Age of Residents**

The median age of residents entering rental facilities is 80 years for females and 79 years for males, which is slightly higher than the average entry age of entrance fee projects. Rental facilities also report a slightly higher median age of residents. As with entrance fee facilities, the age of the facility does not have an impact on the median age of the residents.

	Average Age at Entry to Apartments During the Last Three Years		Average Age of All Residents 1986	
	Female	Male	Female	Male
RENTAL FACILITIES:				
ENTIRE U.S.	80.0	79.0	83.0	81.0
AGE:				
Built Before 1975	80.0	79.0	83.0	83.0
Built 1975 & Later	80.0	79.0	82.0	80.0

*All amounts are medians

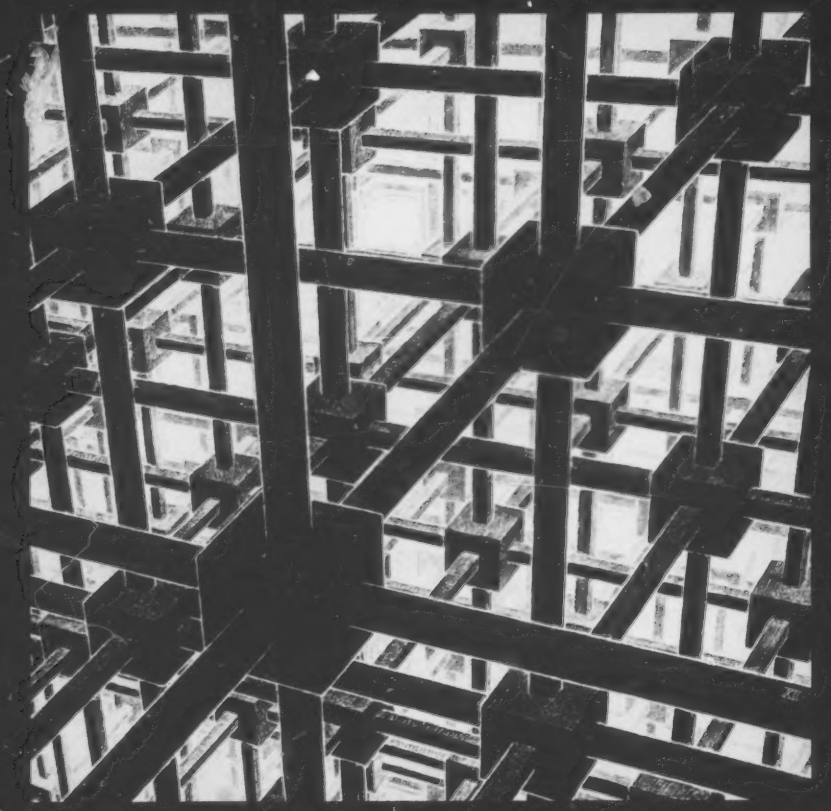
*EXHIBIT IV-8: Annual Apartment Turnover per 100 Residents by Age of Facility**

Exhibit IV-8 reports the median rates of death and transfer for men and women per 100 apartment units. The combined turnover column adjusts the total turnover rates for the previously reported percentage of males and females. The combined total column reports the adjusted turnover rates and includes voluntary withdrawals.

While a similarity exists between rental facilities and entrance fee facilities, rental facilities have a higher number of permanent transfers to nursing centers and personal care/assisted living units (Exhibit III-8). This result, which is consistent with last year's study, suggests a comparatively high level of frailty among residents.

	Deaths		Permanent Transfers to Nursing Center		Permanent Transfers to Personal Care/Assisted Living		Total Turnover		Combined Turnover	Combined Total[1]
	Female	Male	Female	Male	Female	Male	Female	Male	Total	Total
RENTAL FACILITIES:										
BUILT BEFORE 1975										
1986	5.1	8.1	8.7	13.4	4.0	**	16.7	19.2	17.7	21.0
1985	5.6	7.7	6.8	7.7	7.0	**	18.2	14.6	17.7	18.4
1984	5.0	11.8	6.8	7.1	6.5	**	17.8	21.1	18.2	19.1
BUILT 1975 AND LATER										
1986	4.9	12.2	8.5	10.4	3.6	6.9	16.0	22.2	18.8	21.8
1985	3.7	8.3	6.4	15.2	2.9	5.5	14.1	15.4	14.7	18.0
1984	3.3	11.6	6.5	12.0	4.0	3.3	14.6	18.5	15.5	19.1

*All amounts are medians.
Each item was individually tabulated.
**Insufficient response.
[1]Combined total includes all voluntary withdrawals.



Cubic Space Division

M.C. Escher (1898-1972)

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Baarn—Holland

Design and Architecture

At first glance, a senior living facility may look like any other apartment complex, but subtle design details for the elderly can mean the difference between a high quality of life and a constant struggle with living space.

Architects must be keenly aware of the physical limitations of the elderly while designing spaces that offer a sense of independence, comfort, community and privacy. Whether it is the residential portion or the nursing home section of the facility, the design must take into account the constant balance between independence and the security that the elderly individual strives to maintain.

Residents may be healthy when they enter a facility, but as they age, design considerations may be required to allow them to continue to live in the community. Developers, therefore, should pay attention to major features such as adequate lighting and barrier free bathrooms, and subtle nuances including raised electrical outlets. In that way, a project can offer the surroundings to provide a comfortable, but independent life style for the elderly.

SECTION C: REVENUES

EXHIBIT IV-9: Monthly Fees by Selected Criteria

Exhibit IV-9 presents the monthly fees charged for various types of units by location, age and size of the facility. Generally, monthly fees are higher for rental facilities than for entrance fee facilities (Exhibit III-13). This is expected because monthly fees for rental facilities must cover operating costs as well as any debt associated with construction of the facility.

Among rental facilities, newer and larger projects report the highest monthly fees.

	One Person					
	Studio			One-Bedroom		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
RENTAL FACILITIES:						
ENTIRE U.S.	$397	$604	$898	$569	$825	$1,133
LOCATION:						
Urban	381	695	969	563	825	1,195
Suburban	397	600	898	474	825	1,181
Rural	**	540	**	464	838	1,031
AGE:						
Built Before 1975	281	549	734	575	745	964
Built 1975 & Later	433	730	969	556	894	1,181
SIZE:						
Under 150 Units	324	575	786	495	795	964
150 Units & Over	443	614	915	549	971	1,195

**Insufficient response

EXHIBIT IV-10: Nursing Center Daily Rates

Respondent rental facilities with on-site nursing homes reported the daily room rates charged for skilled and intermediate nursing care services. These rates reflect the actual charges for private and semi-private rooms, before any discounts for retirement community residents are applied.

	Private Room			Semi-Private Room		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
RENTAL FACILITIES:						
Skilled Care	$61	$80	$103	$54	$65	$79
Intermediate Care	50	57	80	**	**	**

**Insufficient response

One Person						Additional Fee Second Person	
Two Bedroom			Three Bedroom				
Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	One Bedroom Median	Two Bedroom Median
$573	$ 970	$1,484	$ 582	$1,441	$2,285	$250	$262
569	994	1,783	**	**	**	266	233
195	850	1,558	1,080	1,441	2,248	254	273
**	1,157	**	**	**	**	**	**
425	700	1,383	440	440	440	162	236
573	1,412	1,558	1,080	1,581	2,285	257	252
448	713	1,005	440	440	440	250	258
573	1,248	1,558	1,080	1,581	2,285	257	289

*EXHIBIT IV-11: Rate Increases**

Monthly fees rose slightly for the apartment units of rental facilities, which is identical to the results for Type IB nursing care oriented facilities. The increase in nursing care rates remained at five percent (Exhibit III-11).

	Increase in Apartment Rates	Increase in Nursing Care Rates
RENTAL FACILITIES:		
1986	6.0%	5.0%
1985	5.0	5.0

*All amounts are medians

SECTION D: EXPENSES

EXHIBIT IV-12: Salary Information: Entire U.S.

Exhibit IV-12 presents information on the salaries for various positions at rental communities. The median salary paid by rental facilities and entrance fee facilities is similar, although the only category for which rental communities have the highest median salary is housekeeping and laundry personnel (Exhibit III-14).

	Entire U.S.		
	Lower Quartile	Median	Upper Quartile
RENTAL FACILITIES:			
SALARY PER PERSON FOR:			
Executive Director or Administrator	$28,248	$35,150	$44,500
Assistant Executive Director	14,500	16,860	23,875
Controller	16,484	18,000	32,000
Administrative (Excluding Nursing)	11,025	13,300	17,426
Nursing Center Administrator	21,600	27,500	31,953
Administrative (Nursing)	10,053	13,957	25,000
Nursing Staff	8,836	12,324	15,500
Personal Care Staff	8,228	9,505	13,886
Dietary	8,947	9,988	10,774
Housekeeping & Laundry	8,750	10,080	12,500
Maintenance	12,286	14,400	16,090
Social Activities	10,727	12,654	14,984
Vehicle Drivers	6,121	10,400	13,506
Security	7,938	10,400	12,148

*EXHIBIT IV-13: Salary Information by Size of Facility**

Exhibit IV-13 provides another analysis of median salaries for rental facilities, based upon the size of the facility. In nearly every case, salaries for larger facilities are higher. As with entrance fee facilities, these differences are most pronounced for facility executives.

	Size:	
	Under 150 Units	150 Units & Over
RENTAL FACILITIES:		
SALARY PER PERSON FOR:		
Executive Director or Administrator	$31,200	$39,500
Assistant Executive Director	16,000	24,000
Controller	16,800	22,000
Administrative (Excluding Nursing)	12,300	14,802
Nursing Center Administrator	27,977	27,500
Administrative (Nursing)	13,729	20,000
Nursing Staff	10,800	15,454
Personal Care Staff	9,333	9,677
Dietary	9,082	10,529
Housekeeping & Laundry	10,000	10,115
Maintenance	14,150	15,543
Social Activities	12,967	12,558
Vehicle Drivers	10,374	11,000
Security	9,752	10,700

*All amounts are medians

*EXHIBIT IV-14: Salary Information by Location of Facility**

Salaries for rental facilities, based upon the location of the facility, are shown in Exhibit IV-14). Generally, urban, suburban or rural location does not have as significant effect on salaries as does the size of the facility.

	Location		
	Urban	Suburban	Rural
RENTAL FACILITIES:			
SALARY PER PERSON FOR:			
Executive Director or Administrator	$32,400	$31,650	$30,293
Assistant Executive Director	16,000	18,470	**
Controller	16,800	20,000	**
Administrative (Excluding Nursing)	17,806	14,302	11,000
Nursing Center Administrator	31,900	23,377	27,500
Administrative (Nursing)	13,957	**	16,750
Nursing Staff	10,050	13,273	12,743
Personal Care Staff	9,333	10,545	9,545
Dietary	10,364	9,198	10,115
Housekeeping & Laundry	9,333	10,512	14,962
Maintenance	13,756	14,637	14,400
Social Activities	11,676	12,080	**
Vehicle Drivers	10,700	6,482	**
Security	11,000	9,166	**

*All amounts are medians
**Insufficient response

EXHIBIT IV-15: Number of Employees: Entire U.S.

Staffing patterns for rental facilities are nearly identical to those for entrance fee facilities (Exhibit III-17). The nursing centers of rental facilities are similar in size to those of Type IA principally retirement centers; both are smaller than Type IB nursing care oriented facilities. This accounts for the difference in nursing staff.

	Entire U.S.		
	Lower Quartile	Median	Upper Quartile
RENTAL FACILITIES:			
SALARY PER PERSON FOR:			
Executive Director or Administrator	1.0	1.0	1.0
Assistant Executive Director	1.0	1.0	1.0
Controller	1.0	1.0	1.0
Administrative (Excluding Nursing)	2.0	3.0	5.0
Nursing Center Administrator	1.0	1.0	1.0
Administrative (Nursing)	1.0	2.0	4.0
Nursing Staff	9.0	24.0	34.0
Personal Care Staff	3.0	5.0	8.8
Dietary	5.3	10.0	16.0
Housekeeping & Laundry	2.0	5.0	11.0
Maintenance	1.3	2.0	4.8
Social Activities	1.0	1.0	2.0
Vehicle Drivers	1.0	1.0	2.0
Security	1.0	2.0	3.8

EXHIBIT IV-16: Payroll Expense Statistics

As with entrance fee facilities, many factors contribute to differences in the dietary payroll costs among facilities (Exhibit III-18). Maintenance payroll costs for rental facilities are similar to those for entrance fee facilities; but housekeeping payroll costs are lower. This may be due to the rental service package offering less housekeeping services. To determine the influence of these trends future studies will explore the types of service packages offered.

	Rental Facilities		
	Lower Quartile	Median	Upper Quartile
DIETARY DEPARTMENT			
Dietary Payroll Per Meal	$.90	$1.26	$1.83
HOUSEKEEPING AND MAINTENANCE DEPARTMENT			
Housekeeping Payroll Per Square Foot of Entire Facility	.34	.48	1.38
Maintenance Payroll Per Square Foot of Entire Facility	.20	.40	.65
Square Feet Per Housekeeper	7,932	22,875	41,891
Square Feet Per Maintenance Employee	25,526	39,625	58,018

*EXHIBIT IV-17: Expense Statistics**

As reported in Exhibit III-19, some of the variations in expenses are related to the type of service programs offered by the retirement community. Rental facilities have food costs that are similar to the entrance fee facilities. Utility costs for rental facilities are significantly lower. This may be due to individually metered apartments in which the resident pays his own utilities, thus lowering the total facility costs for utilities.

	Entire U.S.			Size*	
	Lower Quartile	Median	Upper Quartile	Under 150 Units	150 Units & Over
RENTAL FACILITIES:					
Raw Food Cost Per Meal	$.94	$1.28	$1.90	$1.16	$1.77
Utilities Expense Per Square Foot	.70	.97	1.54	.95	1.00
Cost of Food Management Service Per Meal	.11	.21	.28	.13	.25

*All amounts are medians

EXHIBIT IV-18: Reserve Funds

Rental facilities typically do not have a contractual obligation to provide nursing services to their residents. Hence, the amount of reserves for rental facilities is significantly lower than for entrance fee facilities (Exhibit III-20).

	Rental Facilities		
	Lower Quartile	Median	Upper Quartile
TOTAL AMOUNT OF ALL RESERVES	$30,000	$135,000	$469,705
TOTAL RESERVES PER RESIDENT	166	1,201	3,419

EXHIBIT IV-19: Financial Assistance for Residents of Rental Communities: Entire U.S.

Rental facilities report a higher number of residents that require financial assistance than entrance fee facilities (Exhibit III-21). The greater number could be attributed to the fewer number of rental facilities that screen residents. This is changing, as more rental facilities are screening residents (Exhibit II-12).

Residents Currently Requiring Assistance		Current Residents Who Will Require Assistance	
Lower Quartile	3.0%	Lower Quartile	4.0%
Median	17.0	Median	10.0
Upper Quartile	48.8	Upper Quartile	30.0

SURVEY METHODOLOGY & DATA ANALYSIS

by William R. Evans

The survey methodology and data analysis for this seventh annual edition of RETIREMENT HOUSING INDUSTRY 1987 conform closely with the methodology employed in prior years. The main exception is in data analysis, where regional classifications were changed to provide the reader with more specific information.

Survey questionnaires were distributed to a random sample of retirement facility administrators throughout the United States. To be included in the sample, facilities had to meet certain specifications, including being in operation for at least one year. We requested operations and financial information for the most recent complete fiscal year, although in several cases we asked for information from two fiscal years for comparison. Standardized guidelines and procedures for handling questionnaires were established before the analyzation of the respondents' data. Completed questionnaires were carefully reviewed for accuracy and reasonableness. Laventhol & Horwath holds all operating and financial data reported by the participants in strictest confidence.

The response rate for this year's survey was the largest since L&H began conducting a study on the retirement housing industry. The volume of information reported here is significantly larger than last year. L&H provides this report because we believe the response supplies relevant data on operating and financial characteristics of retirement housing facilities.

All data presented in the exhibits originated from L&H questionnaires. The data, therefore, is subject to nonsampling errors, e.g., differences in the interpretation of questions by respondents. However, precautionary steps were employed in the collection and processing of the data to minimize the effect nonsampling errors.

Medians and quartiles comprise the majority of the figures in this report. These statistics were used to prevent the results of any line item from being distorted by an extremely high or low response. A median is defined as the middle figure in a column of data arranged sequentially. For example, if we received nine responses for the number of full-time employees such as 8,4,2,6,9,7,5,1,3, then these numbers arranged sequentially would be 1,2,3,4,5,6,7,8,9. The middle value 5 would be the median since 50 percent of the responses received fall below this value, and 50 percent are above it.

In some exhibits, the sample has been divided into four equal parts or quartiles. When the responses are arranged sequentially, the lower quartile is the value separating the lowest 25 percent from the rest of the sample. The median is still the middle value, and the upper quartile defines the boundary of the upper 25 percent of the responses. Half of all responses fall between the upper and lower quartiles.

It is important to remember that each line item in the study is analyzed separately. Since not all retirement housing facilities reported data for each line item, medians are based on the information submitted for each individual line. Hence, columns reported in median amounts will not necessarily add to 100 percent or the particular total presented. In exhibits where individual lines adding to the total are desirable, arithmetic means are used.

The figures in this report are intended to serve as guidelines, not as standards or goals. Laventhol & Horwath is not attempting to set or conform prices or operating ratios for the industry. Questions about the exhibits or survey methodology should be directed to L&H's Research Division in Philadelphia (215) 299-1600.

We look forward to publishing this survey. Each year, respondents have made insightful comments about the survey questions and design, helping us refine future surveys. We urge readers to share their views on the significance of the publication's contents.

William R. Evans is a research associate in Laventhol & Horwath's Research Division, which is headquartered in the firm's Executive Offices in Philadelphia.

Laventhol & Horwath

Health Care and Real Estate Advisory Services

Executive Offices: 1845 Walnut Street, Philadelphia, PA 19103
215-299-1600 Telex: 83-1396 HORWINTAS PHA

Arizona
3200 N. Central Ave., 16th Floor
Phoenix, AZ 85012
602-234-0900

5151 E. Broadway, Suite 1200
Tucson, AZ 85711
602-790-2255

California
650 Town Center Dr., Suite 1100
Costa Mesa, CA 92626
714-556-4244

3699 Wilshire Blvd.
Los Angeles, CA 90010-2726
213-381-5393
Telex: 4992753 HORWINTAS LSA

Two Century Plaza, Suite 3700
2049 Century Park East
Los Angeles, CA 90067
213-553-1040
Telex: 5564607

P.O. Box 121525
101 W. Broadway, Suite 1300
San Diego, CA 92101
619-236-1000

425 Market St., Suite 3600
San Francisco, CA 94105
415-896-1800
Telex: 384061

Colorado
370-17th St., Suite 2100
Denver, CO 80202
303-595-4000
Telefax: 303-825-7132

Connecticut
Park City Plaza
10 Middle St.
Bridgeport, CT 06604
203-333-5133

District of Columbia
1101-17th St. N.W., Suite 1200
Washington, D.C. 20036
202-296-2250

National Tax Services Group
1101-17th St., N.W., Suite 704
Washington, D.C. 20036
202-463-0700

Florida
Two Alhambra Plaza
7th Floor
Coral Gables, FL 33134
305-442-2990
Telex: 264822 LH MIA UR

500 E. Broward Blvd., Suite 1400
Ft. Lauderdale, FL 33394-3089
305-760-9000

Ashley Tower
100 S. Ashley Dr., Suite 1500
Tampa, FL 33602
813-228-7555

1645 Palm Beach Lakes Blvd
Suite 1100
West Palm Beach, FL 33401
305-689-6600

Georgia
225 Peachtree St., N.E.
Suite 2100, South Tower
Atlanta, GA 30303
404-581-0100

Illinois
P.O. Box 2618
1116 W. Main St.
Carbondale, IL 62902-2618
618-457-8158

300 S. Riverside Plaza
Chicago, IL 60606
312-648-0555

40 Skokie Blvd., Suite 500
Northbrook, IL 60062
312-498-3400

Marriott Commerce Bldg.
509 S. Sixth St.
Springfield, IL 62701
217-544-8955

Indiana
One American Square
Box 82051, Suite 2210
Indianapolis, IN 46282
317-631-0700

Maryland
Investment Building
One Investment Place
Baltimore, MD 21204
301-821-8300

Massachusetts
Two Center Plaza
Boston, MA 02108
617-742-6100
Telex: 940899 LAV HOR BSN

Michigan
3000 Prudential Town Center
Suite 3200
Southfield, MI 48075-1358
313-354-6000

Minnesota
100 Washington Square
Suite 1650
Minneapolis, MN 55401
612-332-5500

Missouri
Commerce Bank Building
Suite 1000
1000 Walnut Street
Kansas City, MO 64106
816-221-6500

Ten Broadway, Suite 1000
St. Louis, MO 63102
314-421-1710

Nevada
Valley Bank Plaza, 14th Floor
300 South Fourth Street
Las Vegas, NV 89101
702-384-1120

New Jersey
Turnpike Plaza Bldg.
P.O. Box 11
197 Highway 18
East Brunswick, NJ 08816
201-257-6000

New York
445 Broad Hollow Rd.
Melville, L.I., NY 11747
516-694-0530

919 Third Ave.
New York, NY 10022
212-980-3100
Telex: 236501 LNH UR

1776 Broadway
New York, NY 10019
212-586-6015
Telex: 640279

North Carolina
One NCNB Plaza, Suite 3500
Charlotte, NC 28280
704-377-0220

Ohio
National City Center
1900 E. Ninth St.
Cleveland, OH 44114
216-696-4770

Capitol Square
65 E. State St., Suite 902
Columbus, OH 43215
614-221-9494

8256 E. Market St., Suite 127
Warren, OH 44484
216-856-2134

Oregon
111 S.W. Fifth Ave.
Suite 1800
Portland, OR 97204
503-221-0141

Pennsylvania
P.O. Box 1865
Harrisburg, PA 17105
717-761-7171

Jamestown Building
102 Chesley Drive
Media, PA 19063
215-565-0411

1845 Walnut St.
Philadelphia, PA 19103
215-299-1700
Telex: 83-1396
HORWINTAS PHA

15 S. Franklin St.
Wilkes-Barre, PA 18701
717-822-1174

Puerto Rico
1701 Banco Popular Center
Hato Rey, PR 00918
809-765-5580

Rhode Island
One Hospital Trust Plaza
7th Floor
Providence, RI 02903
401-421-4800

Texas
2121 San Jacinto St.
Suite 1700
Dallas, TX 75201
214-754-7100
Telex: 73090,
HORWIN AS DAL

333 Clay St. Suite 1100
Houston, TX 77002
713-658-107
Telex: 312061
HORWINTAS HOU

Washington
1430 Skyline Tower
10900 Northeast Fourth St.
Bellevue, WA 98004
206-462-9300

2100 Columbia Center
701 Fifth Ave.
Seattle, WA 98104
206-621-1900

DIVISIONS

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Two Center Plaza
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617-742-6100
Telex: 940899 LAV HOR BSN

300 S. Riverside Plaza
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312-930-0002

400 Park Ave.
New York, NY 10022
212-421-9710

919 Third Ave.
New York, NY 10022
212-980-3100
Telex: 236501 LNH UR

1845 Walnut St., Suite 1400
Phila., PA 19103
215-563-9930

1710 E. Indian School Rd., Suite 201
Phoenix, AZ 85016
602-277-2371

1099 Wall Street West
Lyndhurst, N.J. 07071
201-896-9616

CONSTRUCTION CONSULTING DIVISION

Levien, Rich & Company
305 East 46th Street
16th Floor
New York, NY 10017
212-832-0450

300 South Riverside Plaza
Chicago, IL 60606
312-648-0555

2121 San Jacinto Street
Suite 1700
Dallas, TX 75201
214-754-7100

425 Market Street
Suite 3600
San Francisco, CA 94105
415-896-1800

BUSINESS MANAGEMENT

Two Century Plaza, Suite 3700
2049 Century Park East
Los Angeles, CA 90067
213-553-1040
Telex: 696374

1776 Broadway
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212-586-6015
Telex: 640279

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617-742-6766

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312-368-0200

National City Center
1900 East Ninth St.
Cleveland, OH 44114
216-696-7326

2121 San Jacinto St., Suite 1700
Dallas, TX 75201
214-953-0915

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303-595-4414

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713-877-0200

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Princeton Pike Office Park, CN 30
Princeton, NJ 08543-0030
609-896-0300

Park 270 Building I, suite 202
1807 Park 270 Dr.
St. Louis, MO 63146
314-576-0035

One Metropolitan Plaza
425 Market St.
San Francisco, CA 94105
415-974-5382

HORWATH & HORWATH INTERNATIONAL
Headquarters: 919 Third Avenue, New York, NY 10022
212-980-3100 Telex: 236501 LNH UR
(Partner and correspondent firms in these countries)

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Mary P. Maloney
Director, Health Care Communications
Laventhol & Horwath
1845 Walnut Street
Philadelphia, PA 19103
(215) 299-1600
Or your local L & H representative

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The quality of our data depends on the number of responses we receive from retirement housing facilities throughout the country. Our goal is to increase the number of responses each year. We invite all retirement housing facilities to participate. Simply complete and return this reply card. L&H's Research Division will mail questionnaires for the 1988 study (1987 data) in early 1988. The deadline for participation is June 1; however, if you are reading this notice after this date, send in the reply card to receive a questionnaire for the 1989 edition. To show our appreciation for your participation, we'll send you a free copy of the edition to which you contributed.

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